REHABILITATION

People with mental health problems

Vocational rehabilitation counselors

Mental health practitioners

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KU Leuven
Biomedical Sciences Group

Faculty of Medicine

Department of Public Health

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Summary

Employment constitutes a major and important part of our lives and contributes to welfare and well-being. Yet, the competitive employment rate of people with (severe) mental health problems is low. The Individual Placement and Support (IPS) model of Supported Employment is an evidence-based vocational rehabilitation (VR) model proved to increase competitive employment rates. For this, IPS programs adhere to some important principles, e.g., working with patients' preferences, quick job searching, focusing on competitive employment and integration of employment counselors in mental health teams.

Within the VR process, three stakeholders need to join forces: the patient, the mental health practitioner and the VR counselor. The VR process can be hindered when the patient and the mental health practitioner have different ideas and goals concerning the VR process. Moreover, when even the VR counselor is not intending to focus on competitive jobs, low competitive employment outcomes can be expected. Although there is some proof that the abovementioned barriers can occur, many questions remain. This doctoral project aims to increase knowledge and consists of two research parts covering three studies.

In the first research part we answered the following questions: "Which vocational goals are held by hospitalized patients with severe mental health problems?" and "Do patients and mental health practitioners hold the same perspectives concerning VR goals, barriers and support?". For this, a cross-sectional study was conducted in which patient questionnaires were linked with answers of their mental health practitioners. The second research part covered two studies. First, VR programs were assessed on whether they implement IPS principles. Second, we answered the question "What determines VR counselors' intentions to focus on competitive jobs?" using a questionnaire based on the Theory of Planned Behavior.

The results of the first studies show that more patients than practitioners find a competitive job a prospect. They also hold different perspectives concerning vocational barriers and supports needed to overcome goals. In the second research part, we conclude that VR services do not focus enough on intersectoral collaboration with mental health services, on a quick job search and on competitive jobs. VR counselors seem to focus on such jobs when they hold positive attitudes, are supported, have prior experiences with focusing on competitive jobs and when they recognize the fact that their behavior can have an important influence on the life of others (moral aspect of the job).

Different practical implications can be made. Mental health practitioners must actively assess vocational goals and try to work out a treatment plan. The VR counselor must be involved in this process. The VR counselor should be trained and coached intensively in order to stimulate positive

attitudes towards competitive jobs. Colleagues and supervisors must form a solid team in which they offer support to each other. Moreover, practitioners and VR counselors must be regularly informed about the outcomes of VR counseling.

The study calls for more research concerning those who no longer desire a job as a result of inconsistent regulations, stigma, and negative perspectives of professionals.

Samenvatting

Tewerkstelling is een belangrijk deel van ons leven, het draagt bij tot financiële stabiliteit en welzijn. Spijtig genoeg is de tewerkstellingsgraad van personen met psychische problemen zeer laag. Het Individual Placement and Support (IPS)-model van Supported Employment is een wetenschappelijk model dat bewezen heeft dat het tewerkstellingscijfers kan verhogen. IPS programma's houden vast aan enkele principes, waaronder het werken met de voorkeuren van de patiënt, een snelle zoektocht naar jobs, een focus op reguliere jobs en de integratie van een arbeidstrajectbegeleider (ATB-er) in een team uit de geestelijke gezondheidszorg (GGZ).

Gedurende de arbeidsbegeleiding moeten drie kernfiguren hun krachten bundelen: de patiënt, de hulpverlener en de ATB-er. Het proces kan verstoord geraken indien de patiënt en de hulpverlener andere ideeën hebben over de doelen van de begeleiding. Hetzelfde geldt wanneer de ATB-er niet gemotiveerd is om te focussen op reguliere jobs.

In een eerste onderzoeksdeel beantwoordden we de volgende vragen: "Welke arbeidsdoelen hebben gehospitaliseerde patiënten met psychische problemen?" en "Hebben patiënten en hun hulpverleners dezelfde visie over arbeidsdoelen, barrières en mogelijke ondersteuning?" Hiervoor werd een cross-sectioneel onderzoek opgezet waarbij antwoorden van patiënten gekoppeld werden aan die van hun hulpverleners. Het tweede onderzoeksdeel bevat twee studies. In een eerste studie werd nagegaan of arbeidsprogramma's IPS-principes implementeren en welke barrières ze ervaren. In een tweede studie beantwoordden we de vraag: "Wat bepaalt de intentie van een ATB-er om te focussen op een reguliere job?". Hiervoor werd beroep gedaan op de Theory of Planned Behavior.

De resultaten van het eerste onderzoeksdeel tonen aan dat meer patiënten dan hulpverleners een reguliere job in het vooruitzicht stellen. Ze hebben ook een ander beeld van de bestaande barrières en ondersteuning die nodig is. In het tweede onderzoeksdeel wordt besloten dat arbeidsdiensten te weinig focussen op intensieve samenwerking met de GGZ, op een snelle start van de begeleiding en op reguliere jobs. ATB-ers blijken meer gefocust op reguliere jobs indien ze een positieve attitude hebben van zo'n jobs, ondersteund worden, ervaring hebben en beseffen dat hun werk een invloed heeft op het leven van anderen (morele dimensie).

Er volgen verschillende praktische implicaties. Hulpverleners moeten de arbeidsdoelen van patiënten actief bevragen en een gezamenlijk plan opstellen. Hiervoor moet de ATB-er betrokken worden. Deze ATB-er moet voldoende getraind en gecoacht worden zodat hij/zij een positieve attitude heeft ten opzichte van competitieve jobs. De collega's en supervisoren moeten een hecht team vormen waarin men elkaar de nodige ondersteuning biedt. Alle betrokken hulpverleners en ATB-ers moeten regelmatig geïnformeerd worden over de uiteindelijke resultaten van de begeleiding.

Het onderzoek nodigt uit tot verdere studies bij degenen die niet meer willen werken als gevolg van de inconsistente regelgeving, stigma en negatieve verwachtingen van begeleiders.

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List of abbreviations

ACT	Assertive Community Treatment
AIDS	Acquired Immune Deficiency Syndrome
ASE	Attitude - Social Influence - Efficacy-model
ANOVA	Analysis of Variance
BAKES	Behavior, Attitude and Knowledge of Employment Specialists
FACT	Flexible Assertive Community Treatment
GTB	Gespecialiseerde Trajectbegeleiding en -Bepaling (Vocational Training Agency)
GOB	Gespecialiseerde opleidings-, begeleidings- en bemiddelingsdienst (Vocational Counseling Centers)
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IBM	Integrated Behavioral Model
IPS	Individual Placement and Support
MMPP	Medical, mental, psychological or psychiatric (problems)
OECD	Organization for Economic Co-operation and Development
PBC	Perceived Behavioral Control
PES	Public Employment Service, see VDAB
RIZIV	Rijksinstituut Voor Ziekte en Invaliditeitsverzekering / National Service for Medical and Disablement Insurance
SE	Supported Employment
SEM	Structural Equation Modeling
SMI	Severe mental illness
TPB	Theory of Planned Behavior
TRA	Theory of Reasoned Action
US	United States
UK	United Kingdom
VAPH	Vlaams Agentschap voor Personen met een Handicap / Flemish Agency for People with a Disability
VDAB	Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding, see PES
VR	Vocational rehabilitation
WHO	World Health Organization

Chapter 1

Introduction

Almost one in four people will be affected by mental disorders at some point in their lives (WHO, 2013). On their quest to full citizenship and rehabilitation, many people value the possibilities that employment offers, e.g., more diverse social contacts, a steady income or feelings of being useful. Yet, many people with severe mental illness (SMI) have problems finding and holding jobs. Luckily, effective vocational rehabilitation (VR) models exist. Nevertheless, employment of people with SMI is often fraught with skepticism and doubts. When mental health practitioners or VR counselors do not believe in the possibility of employment, low competitive employment outcomes can be expected.
To improve vocational rehabilitation practices and employment outcomes, this doctoral research focused on three stakeholders of the VR process: the VR counselor, the mental health practitioner and the person suffering from SMI. Our first aim was to investigate the vocational goals of hospitalized patients as past research has often overlooked this group. We also wanted to explore what mental health practitioners perceive as realistic for their patient. A second aim was to examine what constitutes VR counselors' motivation to (not) focus on competitive jobs for people with SMI.

This first chapter offers the reader an overview of what is currently known concerning the topic under study, i.e., the employment of people with severe mental illness. In the first section, we describe the changes and evolutions in mental health care. Next, we discuss the value of employment and the employment rates of people suffering from SMI. In a third section, we describe international VR models and give a description of the VR context in Belgium. We also append some barriers to attain high competitive employment rates. The last section goes further on barriers that relate to people with SMI themselves and their counselors.

1. Evolutions in mental health care

1.1 Definition of severe mental illness

New discoveries in science, the upcoming of paradigms such as the recovery paradigm or altered societal views make it hard to formulate definitions and categorizations of mental disorders. Although an international debate on the definition of SMI exists, a definition with a wide consensus is that of the National Institute of Mental Health in the United States (Ruggeri et al., 2000). This definition categorizes individuals as having SMI when they meet three criteria, called the three Ds (National Institute of Mental Health, 1987; Ruggeri et al., 2000):

- Diagnosis; any non-organic psychosis or personality disorder

- Duration; a history of mental illness or treatment of minimum two years
- Disability; this criterion comprises five domains: reduced working abilities, reliance on public financial assistance, limited personal support system, basic living skills, and inappropriate social behavior resulting in intervention by the mental or judicial system.

This definition is more and more altered as non-psychotic disorders can be severe as well and many people do not experience a pre-defined syndrome but an interform of syndromes (Kendell & Jablensky, 2003; Van Os, 2014). In those cases, other variables than diagnosis may be better indicators of the level of severity of the illness, e.g., the level of general psychopathology or the level of impairment (Stordal et al., 2005). As a consequence, alternative definitions focus more on duration and functioning criteria and often include more types of mental disorders (Parabiaghi, Bonetto, Ruggeri, Lasalvia, & Leese, 2006), e.g., bipolar disorder, obsessive-compulsive disorder or substance abuse disorders.

An alternative definition meeting the abovementioned considerations is that of Delespaul and the 'consensusgroup severe mental illness' of the Netherlands (Delespaul & Consensusgroep EPA, 2013). They state that a severe mental illness is present when:

1 a person suffers from a mental health disorder (and symptoms) that requires treatment and care
2 there are severe social impairments
3 the impairments are the consequence and result of a mental health disorder
4 the mental health disorder is not a passing problem (it is long-lasting, at least a couple of years)
5 coordinated care and treatment of specialized professionals is needed to realize the treatment plan

Due to differences in definitions and methods, the number of people suffering from common and severe mental disorders is hard to estimate. We do know that every year mental disorders affect more than a third of the population (WHO, 2013). Although the prevalence rates did not change significantly during the last ten years (Kessler et al., 2005), mental disorders are now one of the most significant public health challenges in the European Region. This is due to their contribution to overall burden of disease or disability affecting personal, public and economic life (WHO, 2013).

Concerning the prevalence of SMI, different studies exist but none were performed in Belgium. Studies in the Netherlands showed that about 3.5 to 3.8 people out of 1000 suffer from SMI (Kroon, Theunissen, van Busschbach, Raven, & Wiersma, 1998; Wiersma et al., 1997). Using this prevalence rate, it was estimated in 2004 that of the almost 8 million Belgians older than 20 years, about 27.000 to 30.000 people suffer from severe and long-term mental disorders (De Rick, Van Audenhove, & Lammertyn, 2002; Kroon, Theunissen, van Busschbach, Raven, & Wiersma, 1998; Wiersma et al.,

1997). Yet, these numbers are based on the stricter definition of SMI (three Ds). New studies in the Netherlands using the definition of Delespaul et al. showed that about 1.7% of the total population suffers from severe mental health problems (Delespaul & Consensusgroep EPA, 2013). For Belgium, we therefore estimate that the number of people suffering from SMI (including other than psychotic disorders) in 2014 is about 190.000 people on a population of 11 million.

1.2 Evolutions in care and treatment

Mental health care has a major responsibility as it needs to offer effective treatment and care to a large group of people. The history of this treatment and care can be divided in three broad periods; the rise of the asylum, the decline of the asylum due to a focus on recovery and the reform of mental health services into more balanced care (Thornicroft & Tansella, 2004; Van Audenhove, Van Humbeeck, & Van Meerbeeck, 2005).

In a first period, between 1880 and 1950, mental health care was offered in large institutions called asylums. The purpose of asylums was to offer a place to live to people who suffer from SMI. Due to the medical perspective, most care and treatment was directed to the physical condition of the person and less attention was paid to mental, social or spiritual aspects of life.

After the 1950's, a reduction of the number of asylums was possible due to the improved pharmaceutical treatment of mental health disorders and the psychosocial rehabilitation and recovery paradigm (Anthony, 1993). These paradigms state that professionals need to focus on *encouraging patients to develop their fullest capacities through learning procedures and environmental supports (Bachrach, 1992 ; p. 1456)*. Otherwise stated, it is important to focus on maximizing the individual's quality of life by stimulating personal recovery and successful community integration. In order to recover and receive good care, studies showed that it is essential that (Bachrach, 2000; Van Weeghel, 2010; Van Weeghel et al., 2005):

1. the care receiver shapes the direction of the rehabilitation plan and is thus empowered to select the proper goals and to express wishes, frustrations and reservations. As such, the rehabilitation plan is highly individualized,
2. there is a focus on the care receiver's strengths and on restoring hope. This implies that caregivers remain optimistic about the vocational future of mentally ill people. Besides work, other important life domains are of a medical, social and recreational nature,
3. the recovery process starts early after the onset (of treatment or illness) and continues over time and across settings,
4. necessary skills are gained by exercising in realistic life circumstances (place-then-train),

5. the process of support is ongoing as the care receiver is constantly facing new barriers and developing new goals,
6. the social network is included to support the person,
7. care receivers trust their professional. For this, they need to be treated with respect and their own experiences need to be taken seriously.

For this all to become true, treatment and care were increasingly offered in primarily or even exclusively community settings and the number of psychiatric beds was decreased (Bachrach, 2000)

The tenets of the two first periods were often seen as incompatible (Thornicroft & Tansella, 2002). Yet, in the beginning of the 21st century the awareness rose that both prior models do not have to be regarded as a strict dichotomy. This proved to be the beginning of a model of balanced care; the close collaboration between both modern hospital-based and modern community-based care (Thornicroft & Tansella, 2002; Thornicroft & Tansella, 2013). Such 'balanced care' aims to provide treatment and care close to the natural environment of the patient and is thus very mobile. It incorporates the tenets of the abovementioned recovery paradigm, focuses on highly individualized treatment and is consistent with international conventions on human rights. In high resource settings, optimal balanced care is defined by three layers, including (i) primary care of mental health (psychosocial treatment, pharmacological treatment), (ii) general adult mental health services and (iii) specialized adult mental health services that offer more intense and expert interventions (Thornicroft & Tansella, 2013). The latter two types of services consist of for example ambulatory clinics, community mental health teams, acute in-patient care, long-term community-based residential care and services focusing on work and occupation. The last layer is offered to specific groups with poorly met needs (Thornicroft & Tansella, 2013). Yet, in reality it is noticed that specialized services are often implemented either in the absence of the first two layers or independent of them (Thornicroft & Tansella, 2013). This makes the provision of care unbalanced and expensive.

High quality balanced care also includes offering practices that are evidence-based. During the past decades, randomized controlled trials and other tests proved six evidence-based practices in mental health (Mueser, Torrey, Lynde, Singer, & Drake, 2003):

- collaborative psychopharmacology; working towards the right mix and the right amount of medications to decrease symptoms
- assertive community treatment (ACT); a community mental health service approach that focuses on outreaching and intensive support by a multidisciplinary team
- family psycho-education; providing information about illnesses and management of illnesses and providing social support and empathy in order to help families understand and cope

- supported employment; finding, placing and supporting patients in jobs
- illness management and recovery skills; offering patients information and skills needed to understand and manage their illnesses and participate in treatment options
- integrated dual disorders treatment; treating both types of the different present disorders as primary disorders in the same setting.

More specifically for Belgium, it has to be said that Belgium has complex governmental structures that can hinder the development of comprehensive mental health policies (Hermans, de Witte, & Dom, 2012). About 10% of the gross domestic product (GDP) is spent on healthcare but only 6% is allocated to mental health. Mental healthcare is largely accessible and offers high levels of quality, but the economic climate challenges the current system.

The colony of Gheel is famous as it is seen as the birthplace of family care. From the eighteenth century, people with mental illness were offered a place at the houses of inhabitants (Liègois, 1991). In contrast with this family care, there is also historically a focus on in-patient hospitalization (Liègois, 1991). Even now, Belgium has the second-highest number of beds per capita in the world (179 psychiatric beds per 100.000 population) (Samele et al., 2013). Although reports on duration of hospitalization are scarce, some estimate that hospital duration often exceeds 10 weeks (Schoevaerts et al., 2014; Umbach & Vanrillaer, 2014). At the time of this PhD study, the mental health care context was being reformed (www.psy107.be). Policy makers acknowledged the advantages of balanced care and the delivery of mental health services close to the home of the person. Therefore, they now aim to reduce the high number of psychiatric beds. The financial resources that are saved with closing beds are offered to local networks of mental health services including for example psychiatric hospitals, primary care services, low-threshold social services, supported housing initiatives and employment services. The networks are instructed to put a solid community-based alternative in place, to take into account the needs of citizens and to strive towards more optimal community integration. This reform is currently undertaken in 19 regions. Due to the stimulation of ambulatory services, hospitalization rates should decrease and patients can remain in their own social context while receiving support. Moreover, patients should experience more continuity of care as services should cooperate closely while focusing on multiple important life domains (e.g., mental health, housing, prevention, employment).

2. Employment

According to the psychosocial rehabilitation and balanced care paradigm, it is important to offer people effective services that enable them to integrate into the community. For this, both paradigms value the role of work and employment. Before we offer an explanation why work and employment are given so much credit, we will clarify what we mean by 'employment' and present the (un)employment rates of people suffering from mental disorders.

2.1 Definitions of work and employment

Although the concept of work is defined differently across societies, work has long been synonymous with paid employment in Western societies (Benschop, 1995; Taylor, 2004). Moreover, some have argued that work needs to result in a material surplus and is mandatory (van Santen, 1985 in Van Weeghel, 1995). By defining work so narrowly, there is no room for housework, caring for a sick relative, being a cashier at the local people's theater or other voluntary work (Taylor, 2004). Yet, such activities are still quite different from leisure activities such as going for a walk or gardening on a Sunday afternoon. Therefore, work is nowadays defined as activities that are not completely freely chosen in order to relax and these activities often take place within limits set by others, i.e., you do it for other people and these people may indicate how you need to achieve the goal, the time you may spend or the environment in which you will need to operate (Boardman, 2003). When a person gets paid for his work, he is said to be 'employed' (Boardman, 2003). Payment is in this case regarded as 'earnings' or 'a wage you get from an employer' and it thus excludes for example reimbursement of expenses, disability benefits or retirement pay. Employment can be further subdivided into two categories, i.e., competitive (regular) and non-competitive employment. Whether or not a job is competitive depends on who 'owns the job', who the colleagues are and how the job was obtained. Competitive employment is defined as: *'employment in integrated work settings in the open job market at prevailing wages with supervision provided by personnel employed by the business'* (Bond, Campbell, & Drake, 2012, p. 752). In competitive jobs people have the opportunity to work alongside non-disabled coworkers (inclusion), jobs are available to anyone (disabled or not disabled) and job seekers need to compete with others to obtain the job (Callahan, 2009). Sheltered workshops, where people with disabilities are employed at an accredited occupationally-oriented facility, are thus non-competitive. The same is true for agency run work crews, crews of disabled workers in regular companies, as most crews do not blend in and the jobs are especially created for people with disabilities (Callahan, 2009).

2.2 Employment indicators

Estimating how many people with SMI are actually (un)employed is difficult due to the use of different definitions of SMI, a lack of research and the fact that rates can vary between regions as a result of for example the local benefit or economic system (Harvey, Modini, Christensen, & Glozier, 2013). To gain an insight into the employment of the target group, we need to consider three indicators, namely employment rates, the number of people out of the labor force, and unemployment rates.

Different studies in the US, Europe and the UK showed that the employment rate[1] of people with SMI is consistently lower than that of the overall population (Luciano & Meara, 2014; Mechanic, Bilder, & McAlpine, 2002; Organization for Economic Co-operation and Development [OECD], 2013b). For Belgium in specific, it is estimated that the employment rate of people with mental disorders is 50%. This is 15 percentage points lower than the employment rate of people without mental disorders (65%) and this 'employment gap' increased with 6 percentage points between 1997 and 2008 (OECD, 2013b).

In addition, it is important to note that employment rates decrease when the severity of the mental illness increases (Figure 1). International studies show that between 12% and 38% of people suffering from schizophrenia have a full-time job (Luciano & Meara, 2014; Mechanic et al., 2002). In the Netherlands, a country comparable with Belgium, the employment rate of persons suffering from SMI situates at the lower bound of this international range (18-19%) (van Erp, Michon, van Duin, & Van Weeghel, 2013).

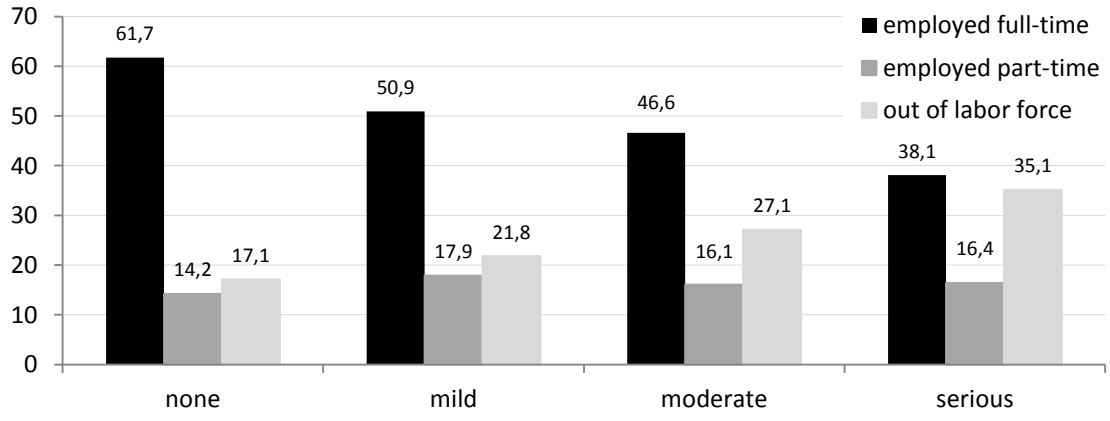

Figure 1. Employment status (full-time, part-time, out of labor force) in percentages (left axis) among American adults (18–64) by severity of mental health problems (horizontal axis) in 2009–2010 (adapted from Luciano & Meara, 2014)

[1] The number of employed people in relation to the working age population

Besides being employed, persons in the working age population can be out of the labor force when they are considered sick or receive disability benefits. Many people with mental disorders without a full-time job are also not working part-time or seeking work (Figure 1) (Luciano & Meara, 2014). They thus seem to be out of the labor force more often (35.1%) compared to adults without mental illness (17.1%) (Luciano & Meara, 2014). In Belgium, an increasing number of people with mental health problems receive disability benefits; nearly one third of all new disability benefit claims in 2010 were due to mental disorders. In the younger age group (aged 20-39 years) almost 50% of benefit claims are due to mental health problems (Figure 2) (OECD, 2013b). The increase in the number of disability benefits receivers is partly the consequence of a better awareness of mental health disorders and the often inaccurate belief that such disorders cause high and permanent work incapacity (OECD, 2012).

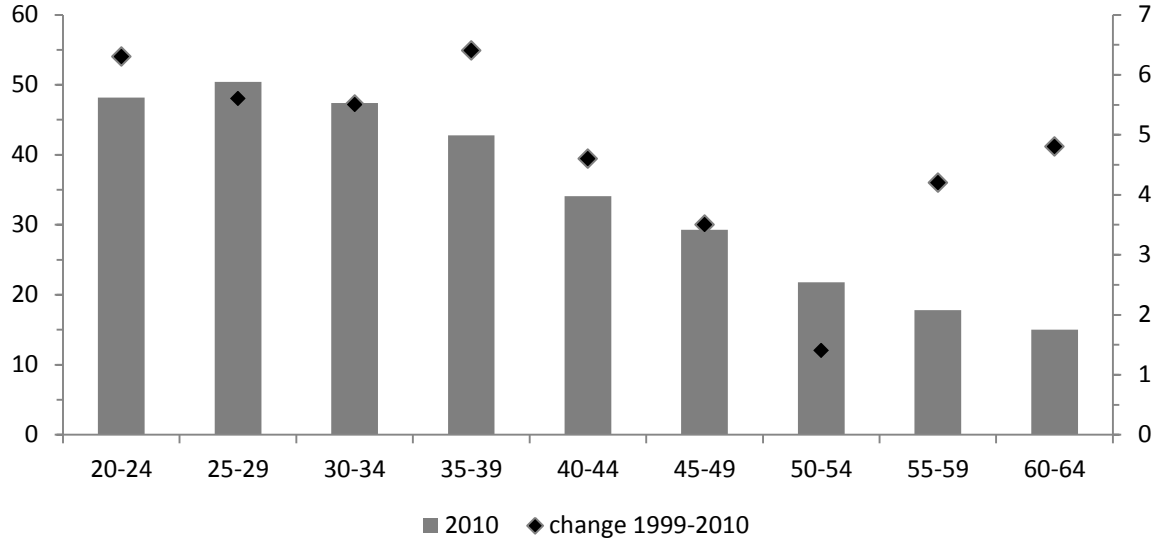

Figure 2. Percentage of new benefits claims due to mental illness in 2010 (bars, left axis) and percentage increase in the number of these claims between 1999 and 2010 (diamonds, right axis) within age groups (horizontal axis). Belgian data (adapted from OECD, 2013b)

When we focus on individuals that are unemployed and are looking for a job, hereby excluding people who are economically inactive such as students or people on disability benefits, we can calculate the unemployment rate[2]. Studies of the OECD show that the unemployment rate is generally two times higher for people with a mental disorder compared to individuals without such a disorder. In Belgium, the unemployment rate was 26.5% for people with severe mental disorders, 17.3% for people with moderate disorders and 9.5% for people without a mental disorder in 2008 (Figure 3) (OECD, 2012). Possible reasons relate to a reluctance of employers to hire people with SMI,

[2] Labor force includes both employed and unemployed people, but not the economically inactive, such as students or pensioners. The unemployment rate only takes in account people actively looking for a job. In Europe, this normally means that job-seekers are registered at a government's office in order to claim unemployment benefits.

a lack of evidence-based vocational support or a lack of awareness of job support (Harvey et al., 2013; Luciano & Meara, 2014).

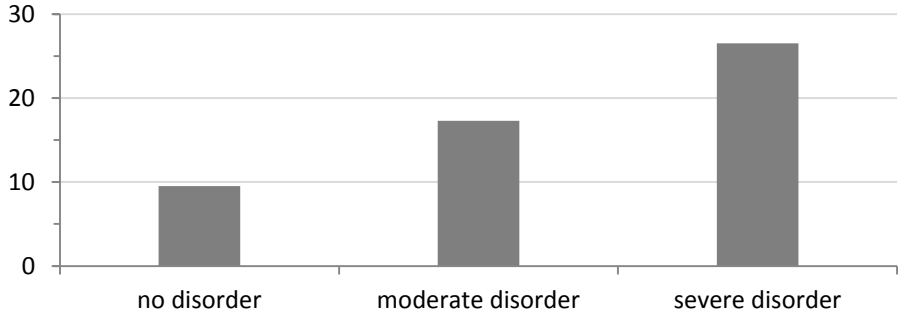

Figure 3. Belgian unemployment rates (%) by severity of mental health problems (OECD, 2012)

2.3 The value of employment

Low employment rates indicate that many people do not have access to the multitude of benefits that employment offers. These benefits are best explained by the latent deprivation theory of Jahoda (1982). This theory states that besides the manifest function (wage), there are also "unintended latent by-products" corresponding to basic human needs (Stiglbauer & Batinic, 2012). The latent functions of employment are more covert than financial gain and include (1) a structuring of time, (2) feelings of being useful and needed by others, (3) social contacts, (4) social status, and (5) an active lifestyle.

Jahoda arguments that employment is the dominant social institution that provides access to all of the latent benefits both simultaneously and sufficiently (Stiglbauer & Batinic, 2012). A lack of access to these benefits, especially a lack of income, social status and time structure, can be detrimental for mental well-being (Creed & Macintyre, 2001; Haro et al., 2011; McKee-Ryan, Song, Wanberg, & Kinicki, 2005; OECD, 2012; Paul & Moser, 2009; Stiglbauer & Batinic, 2012). Unemployed people are two times more likely to suffer from depression, anxiety and psychosomatic symptoms (Paul & Moser, 2009). Moreover, unemployment is associated with an increased risk for physical ill-health and suicide and with an increased mental health services usage (Elhai & Ford, 2007; Milner, Page, & LaMontagne, 2014; Milner, Page, & LaMontagne, 2013; Wong et al., 2014).

Both people without and with mental health problems experience the abovementioned disadvantages of unemployment. When they already suffer from mental health problems, these problems can be exacerbated by unemployment (Paul & Moser, 2009). In contrast, employment can sometimes result in an amelioration of mental health problems due do the abovementioned latent benefits (Boardman, Grove, Perkins, & Shepherd, 2003; Haro et al., 2011; Koletsi et al., 2009; Rinaldi

& Perkins, 2005). When having a competitive job, people with SMI tend to be more satisfied with their daily occupations and spend more time in those daily occupations (Eklund, Hansson, & Ahlqvist, 2004). Jobs can also help a person to place things in a new perspective due to the increased contact with others outside the nuclear family or fellow sufferers (Dunn, Wewiorski, & Rogers, 2008; Marwaha & Johnson, 2005; Provencher, Gregg, Crawford, & Mueser, 2002).
Considering symptoms, work can be a distraction and can help to overcome troubling symptoms (Auerbach & Richardson, 2005; Dunn et al., 2008). Thus, employment does not necessarily have a negative effect on the psychological well-being. Even more, people often show better psychosocial functioning and increased coping with their psychiatric disability (Eklund et al., 2004). Finding employment through evidence-based vocational rehabilitation programs can significantly improve the executive functions (flexibility, inhibitory control, and judgment abilities) and decrease negative symptoms of patients with schizophrenia (Bio & Gattaz, 2011). Employment will further strengthen the effects of other therapeutic interventions and may ultimately enhance self-esteem, self-empowerment and quality of life (Bio & Gattaz, 2011; Bond et al., 2001b; Mueser et al., 1997). It elicits feelings of control, self-efficacy, pride and enjoyment (Provencher et al., 2002).

Nevertheless the many benefits, work can have some disadvantages as well. Although these are often overestimated by mental health professionals (Drebing et al., 2012), work stress due to time pressure, work overload, and long hours can negatively influence the person's well-being (Dollard, Skinner, Tuckey, & Bailey, 2007). Other stressors include reduced autonomy, low job security (Dollard et al., 2007) and a lack of support from the employer or colleagues (Chandler & Repper, 2011). In addition, the person with mental health problems may be confronted with stigma, bullying and harassment (Szeto & Dobson, 2010).

In sum, there is a large group of people suffering from mental health problems and they experience difficulties with living normal lives due to poverty, stigma and unemployment. Participation in employment may for some result in an improvement in well-being, welfare and inclusion (Waghorn & Lloyd, 2005). Not only people with SMI, the state and the society as a whole can benefit from employment of people with SMI as well. High unemployment of people with mental health disorders is not only expensive but it also reduces the chances for a society in which people with different experiences share their thoughts and perspectives. Thus, although people with mental health problems face many hurdles, a job can have many benefits. To help them find and keep jobs, specialized vocational support is often needed (Dunn et al., 2008; Perkins, Farmer, & Lichfield, 2009). Such vocational support can be offered by different models. These models are explained in the next section.

3. Vocational rehabilitation

To overcome vocational barriers it is important to offer effective vocational rehabilitation (VR), defined as '*a comprehensive sequence of services, mutually planned by the consumer and rehabilitation counselor, to maximize employability, independence, integration, and participation of people with disabilities in the workplace and the community'* (Ditchman et al., 2013, p. 345).
A variety of VR models to enhance the vocational capacities of persons suffering from disabilities exist. After we discussed the most important VR models in the next section, we highlight some current difficulties, challenges and gaps concerning the VR of people with SMI. We focus on international challenges and challenges concerning the Belgian context.

3.1 Vocational rehabilitation programs

VR programs can be divided into two categories, i.e., train-then-place programs and place-then-train programs. Traditional train-then-place programs are based on the assumption that it is best to gradually move towards competitive employment. The underlying principle is that jobseekers with disabilities need certain skills prior to becoming competitively employed within the community (Cimera, Wehman, West, & Burgess, 2012). A gradual stepwise process over months or years is perceived as the best approach because a rapid entry in competitive employment could induce too much stress (Waghorn, Lloyd, & Clune, 2009). Examples of train-then-place programs are prevocational training classes (teaching job search and work skills), transitional or trial employment (i.e., part-time work at less than minimum wage and for a limited time) or volunteer placements (Twamley et al., 2005).
Although pre-vocational training is often considered to be a stepping stone to competitive employment, outflow rates are low (Sayce & Curran, 2007). On average 25% of participants of traditional pre-vocational programs find a competitive job and dropout rates are rather high (Bond, Dietzen, McGrew, & Miller, 1995; Michon et al., 2014; Waghorn et al., 2009; Waghorn, Dias, Gladman, Harris, & Saha, 2014).

Place-then-train programs, otherwise called Supported Employment (SE) programs, are fundamentally different from the first approach. The underlying premise is that jobs are searched without an extended preparation and that people are taught the skills they need through a more concrete process of on-the-job coaching (Kinoshita et al., 2013; Twamley, Jeste, & Lehman, 2003; Twamley et al., 2005). Different SE programs exist, but the best-researched model is the Individual

Placement and Support model (IPS). IPS is based on the adherence to some key principles (Becker & Drake, 1994; Bond, 2004; Kinoshita et al., 2013; Marino & Dixon, 2014):

1 IPS-services are focused on competitive employment, i.e., jobs in integrated work settings in the competitive job market at prevailing wages with supervision provided by personnel employed by the business (Bond & Drake, 2012).

2 There is a zero-exclusion policy; eligibility is based on consumers' choice and desire to work. Diagnosis, age or symptoms are no exclusion criteria for entering the program.

3 Jobs are searched rapidly; after a client expresses work interest, intensive job search is offered and no lengthy pre-employment training is obliged.

4 Employment and mental health treatment teams are integrated; employment specialists serve on clients' treatment teams alongside other staff, such as case managers, psychiatrists and social workers.

5 There is attention to patient preferences, strengths and interests when looking for jobs; availability of jobs or assessment procedures do not define job possibilities and on-the-job coaching is recommended.

6 Ongoing individual support and long term follow-up after finding a job is offered.

7 Services offer personalized benefits counseling because a fear of losing benefits is an important barrier to seeking employment (MacDonald-Wilson, Rogers, Ellison, & Lyass, 2003).

8 A newly added principle is that of developing relationships with employers in the community according to client preferences (Marino & Dixon, 2014).

Particularly the integration with mental health services, a rapid job search, a focus on competitive employment and the possibility of support while on the job, distinguish IPS from traditional approaches (Marshall et al., 2014).

To attain good vocational outcomes, services need to adhere strongly to the principles outlined above (Becker, Xie, McHugo, Halliday, & Martinez, 2006; Drake, Bond, & Rapp, 2006; Harvey et al., 2013). Adherence to these IPS-principles may be measured using a fidelity scale (Bond, Peterson, Becker, & Drake, 2012). This scale differentiates between IPS programs and other vocational approaches and has good content and concurrent validity (Bond, Becker, & Drake, 2011; Bond, Becker, Drake, & Vogler, 1997). It is used in this doctoral study and will be further explained there (Chapter 5).

Evidence from 21 systematic reviews including 17 randomized controlled trials of the IPS-model consistently favors it over other vocational approaches (Kinoshita et al., 2013; Marino & Dixon, 2014; Marshall et al., 2014). Competitive employment rates for IPS fall around 65% compared to 25% of controls (mostly pre-vocational services) (Crowther, Marshall, Bond, & Huxley, 2001; Kinoshita et al., 2013; Marino & Dixon, 2014). IPS increases the likelihood of obtaining any employment and the length of competitive job tenure (Kinoshita et al., 2013). Receiving IPS also seems to decrease the time to the first competitive job (Kinoshita et al., 2013; Marino & Dixon, 2014; Marshall et al., 2014). Moreover, for some groups, such as people suffering from autism spectrum disorder, better vocational outcomes are achieved if they do not participate in sheltered workshops prior to enrolling in IPS (Cimera et al., 2012).

The bulk of this evidence comes from the United States where the intervention was developed. Therefore, it was first doubted whether IPS would be successful in West- and North-European countries. Although competitive employment rates are lower, a six-site randomized European trial of IPS (EQOLISE study) showed that IPS was superior to treatment as usual (55% vs. 28%) (Burns et al., 2007). Yet, IPS effectiveness was dependent on the local unemployment rates of the region. In addition, getting a job or not is also depended on the level of the benefit trap in the region. Regions where benefits deemed likely to be higher than salary (e.g., London, Groningen), people where less likely to get a job irrespective of which kind of support they received. Another Dutch study, SCION, showed that after 30 months follow-up, significantly more participants in the IPS group (44%) found competitive work compared with people receiving traditional VR services (25%) (Michon et al., 2014).

Concerning non-vocational outcomes, it is still too early to conclude if being supported by IPS is associated with non-vocational outcomes such as higher levels of quality of life, better mental health and increased use of outpatient mental health services. Firstly, few studies systematically study and report these non-vocational outcomes of IPS (Kinoshita et al., 2013; Marino & Dixon, 2014; Marshall et al., 2014). Secondly, studies that report on these outcomes found mixed effects. Different studies, including a Cochrane review, stated that there was no evidence that IPS affected quality of life, general functioning or symptom levels more compared to other vocational approaches (Drake, Becker, Clark, & Mueser, 1999; Killackey, Jackson, & McGorry, 2008; Kinoshita et al., 2013; Latimer, 2006). Although this seem to indicate that IPS does not offer any non-vocational benefits, recent studies report higher levels of quality of life, better mental health and increased use of outpatient mental health services when IPS services with follow-up and personalized social contact were offered (Drake et al., 2013; Gold, Macias, & Rodican, 2014). This is an improvement as less inpatient mental health services are needed. Moreover, although the use of IPS services may not always have a positive effect on non-vocational outcomes, the result of IPS services (i.e., competitive employment)

does have a positive effect. An increasing number of studies show that being engaged in competitive employment is associated with a positive impact on self-reported mental health, self-esteem and quality of life and less dependency of welfare benefits (Bond, Resnick, Drake, Xie, McHugo, & Bebout, 2001; Michon et al., 2014; Mueser et al., 1997). People are also more satisfied with vocational services, leisure, and finances when working (Bond, Resnick, Drake, Xie, McHugo, & Bebout, 2001)

Due to the amount of evidence, IPS is regarded an evidence-based practice (Bond, 2004; Crowther et al., 2001; Fioritti et al., 2014; Kinoshita et al., 2013; Marshall et al., 2014; Twamley et al., 2003). The model can also be implemented in West- and North-European countries characterized by a less flexible labor market, a relatively protective socioeconomic climate (e.g., due to a benefit trap by which unemployment benefits offer a higher and/or more secure income than wages) and extensive differences in the culture of mental health services compared to the US (Michon et al., 2014).

3.2 The organization of vocational rehabilitation in Flanders

Before 2006, the Flemish Agency for People with a Disability (VAPH) was responsible for employment policies for disabled people. Because the VAPH mainly focused on physical disabilities, few programs for people with mental health problems existed. Mental health organizations often offered day activity programs or referred people to Sheltered Employment (OECD, 2013b). After 2006, the responsibility for employment policies for disabled people was transferred to the Public Employment Service of Flanders (Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding, VDAB). The VDAB became aware that many unemployed people face mental health problems (OECD, 2013b) and started creating new services although they did not create policies for each specific target group. People with problems not related to the labor-market were clustered in the so-called MMPP-group: people with Medical, Mental, Psychological or Psychiatric problems (OECD, 2013b). This group includes for example people with lower back pain, a cleft palate or mental health problems.

When job seekers, with or without a disability, want to find a job and need help, they can contact a gatekeeper of the VDAB at local ‘employment shops’ (Figure 4). Gatekeepers pay attention to employment related aspects such as employment-specific competences and qualifications, job-search behavior, social and communicative skills, mental health problems and secondary conditions (e.g., mobility or childcare). When the gatekeeper perceives some barriers, he can request an in-depth multidisciplinary screening from an external assessment partner (Gespecialiseerde Arbeidsonderzoeksdienst – GA). Since 2014, this center is part of the Vocational Training Agency, a large non-profit center specialized in the activation of job seekers (Gespecialiseerde Traject

Bepalings- en Begeleidingsdienst – GTB) (Figure 4). Self-motivated job seekers with a good chance of finding a job receive some initial guidance from the gatekeeper as well as referrals to vacancies. In addition, the VDAB offers a wide range of active labor market programs, including job-search assistance, training programs, education, etc. At any point in time, the guidance and support can be intensified depending on the needs of the job seeker or the opinion of the gatekeeper.

Job seekers confronted with barriers that are very hard to overcome (e.g., low education, lack of experience, mental health problems) are referred to the above-mentioned Vocational Training Agency (GTB). Case managers of the GTB offer of-the-job support by setting up an individual action plan, intensive job searches and bringing the person in contact with other specialists such as for example psychologists or empowerment coaches. Case managers thus partly coordinate the collaboration between their employment sector and the mental health care sector (psychologists, social workers…).

Although many receive specialized support, this may not be sufficient for all. To help people who need more intense support, a network of 12 non-profit Vocational Counseling Centers (Gespecialiseerde Opleiding, Begeleiding en Bemiddeling - GOB) exists. VR specialists of these centers search for jobs or internships, support employers or colleagues and offer specialized trainings and education. The VR specialists can offer on-the-job training, but this is restricted to a maximum of 800 hours and is mostly offered in internships.

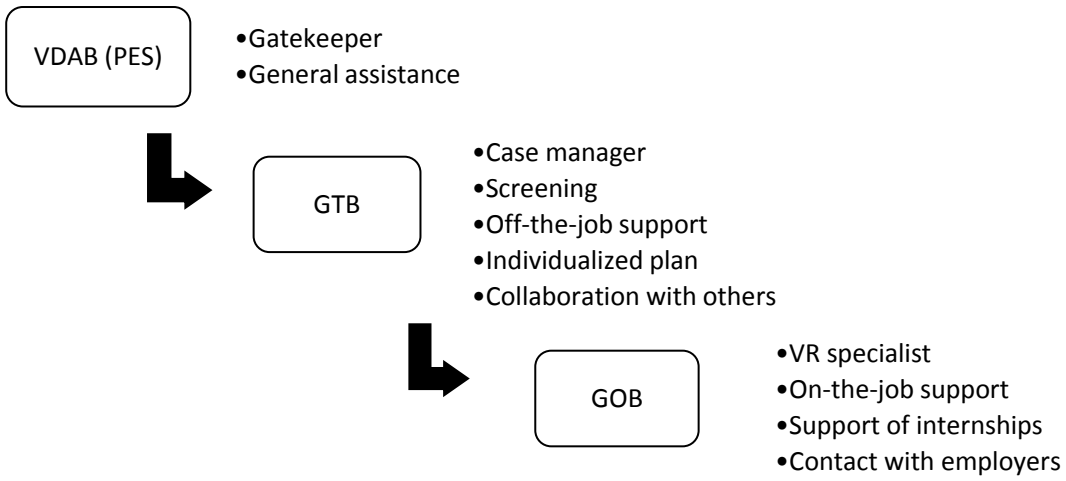

Figure 4. Simplified overview of some Flemish employment services

Along with these three organizations, there are a large number of empowerment coaches, mental health coaches and Sheltered Employment workshops. In Belgium, there is a high reliance on Sheltered Employment (Figure 5). Yet, there is an increase of people with disabilities in competitive employment in the recent years (Shima, Zólyomi, & Zaidi, 2008). In addition, 'arbeidszorg' exists; a system of helping people to get acquainted with job demands by unpaid work while being supported

by specialized counselors. Moreover, many psychiatric hospitals offer in-patient vocational rehabilitation services and created a network of employment partners. Yet, although there is some collaboration, this is not intensive compared to what is needed to fulfill the requirements of IPS.

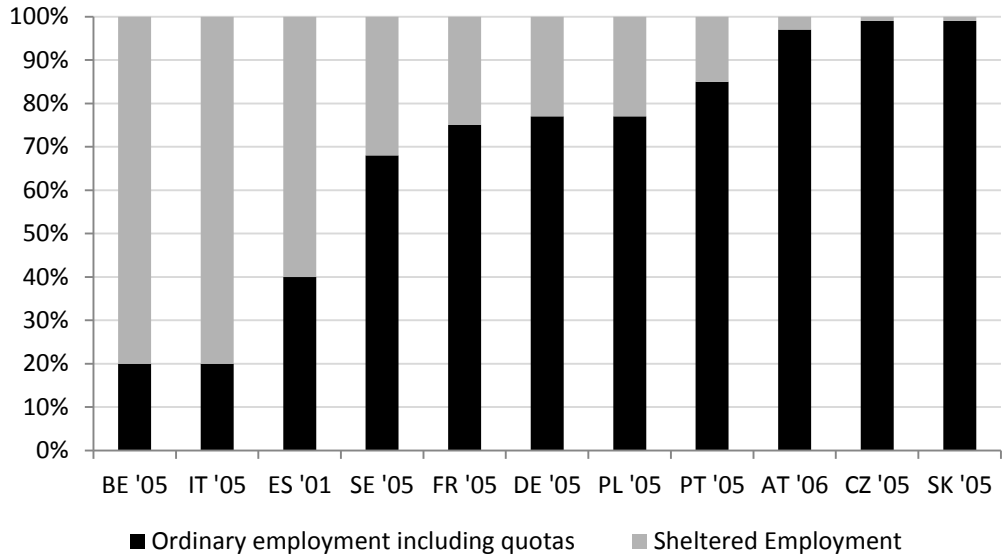

Figure 5. Distribution between ordinary and sheltered employment in 2001 (’01), 2005 (’05) or 2006 (’06) between different EU states (Belgium (BE), Italy (IT), Spain (ES), Sweden (SE), France (FR), Germany (DE), Poland (PL), Portugal (PT), Austria (AT), Czech Republic (CZ), Slovakia (SK)) (adapted from Shima, 2008)

3.2.1 The future of vocational rehabilitation in Flanders

When the VDAB became responsible for the employment of people with disabilities, they introduced different active labor market programs. After a while, the VDAB noticed that MMPP job seekers, and especially people with mental health problems, tend to be over-represented in those active labor market programs (OECD, 2013b). They are much more likely to receive wage subsidies or participate in Sheltered Employment than others with a work disability (e.g., physical impairment, no knowledge of the language). Job seekers with disabilities are less likely to switch to paid work. Of the jobseekers who followed a labor market program, 55% of the immigrants or individuals holding a low educational level found a paid job (both competitive as Sheltered employment) within six months compared to 21% of the MMPP job seekers (OECD, 2013b).

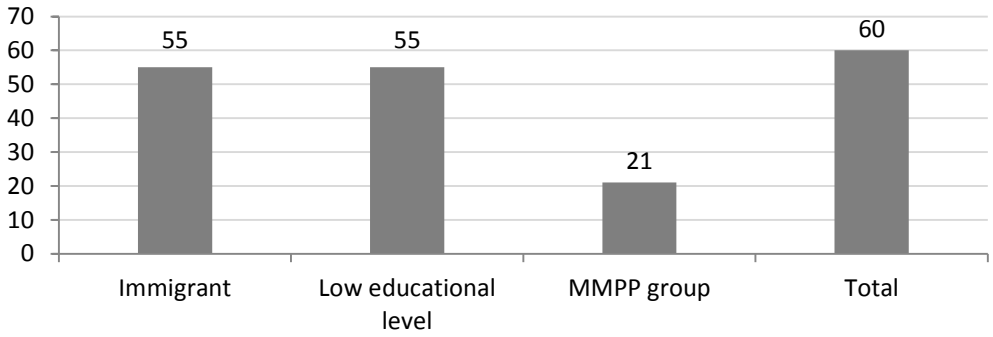

Figure 6. Percentage of job seekers who are employed (including sheltered employment and employment care) six months after finishing an active labor market program - comparison between three subgroups (immigrant, low educational level and MMPP (medical, mental, psychological or psychiatric problems)) and total outcome of active labor market programs after six months (adapted from OECD, 2013b)

To increase employment rates, the VDAB started an experimental collaboration with external partners to provide services combining mental health care, empowerment and employment support. Although this may seem to resemble an IPS-model, collaboration is not of an intensive nature and lengthy pre-vocational aspects are in place. In addition to the increased (but often not intensive) collaboration with external partners, the VDAB improved the screening process and active labor market measures for people with more moderate mental health problems. Due to the success of the collaboration with mental health services, an adapted version is now being formalized in a legislative reform called w² (work and well-being). This reform introduces the 'Participation stair' that aims to represent possible levels of participation (Figure 7). This stair is based on a former Dutch model which is in the Netherlands already reformulated to a 'participation-wheel'[3,4]. The reform attempts to regulate the offering of services for people that are not (yet) ready for competitive employment. It will introduce three kinds of services:

- Temporary services for activation: services are offered for a maximum of 18 months and help the person to find a paid job (in the competitive job market or the 'protected' job market).
- Temporary services for social orientation: people who are not yet (short or medium long period) ready for paid employment are helped to find their optimal level of participation in society.
- Vocational activities: people who are not ready for paid employment on the long term are offered vocational activities.

[3] http://www.participatieladder.nl/treden-participatieladder.html
[4] https://www.movisie.nl/sites/default/files/alfresco_files/Participatiewiel%20gemeenten%20%5BMOV-178057-0.3%5D.pdf

A mental health case manager and a VR case manager will work together to offer individualized services. The level of involvement of the case managers is based upon where the person wants to end up on the participation stair.

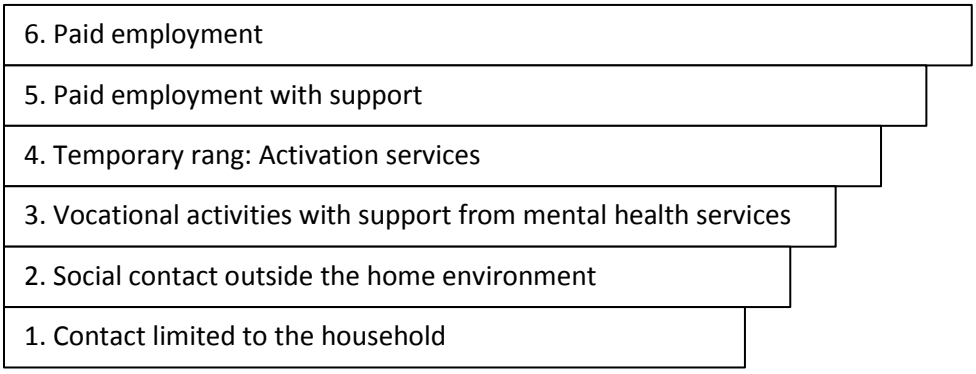

Figure 7. Participation stair

3.3 Barriers, challenges and research gaps

When we take into account the employment interest of people with mental health problems, the value of employment and the low employment rates, it becomes clear that evidence-based IPS programs need to be offered. The implementation of IPS is not straightforward due to micro-, meso- and macro-level barriers and deeply rooted cultural values regarding the employment of people with disabilities (Fioritti et al., 2014). In addition, even the principles of the evidence-based practice of IPS can and need to be further refined (Bond, Drake, & Becker, 2012; Marino & Dixon, 2014; Marshall et al., 2014).

To improve employment rates and non-vocational outcomes there is a need for studying barriers situated on three intertwined levels, namely (A) the macro level, (B) the meso level of VR services and (C) the micro level of people suffering from mental health problems. We describe the challenges on each level and append what it means for the local Belgian VR context.

3.3.1 The macro level

People suffering from mental health problems are more affected by general labor market trends, especially during times of market contraction, compared to people without mental health problems (Cook, 2006). The use of Supported Employment services may partially ameliorate the effects of a poor labor market (Cook, 2006). But even when Supported Employment is offered, many other macro-level barriers remain. One such barrier is the lack of consistent and effective disability and

unemployment policies (Boardman & Rinaldi, 2013; Bond et al., 2012; Drake & Bond, 2008; Taskila et al., 2014). Current policies can for example result in a loss of income when working due to the fact that benefits may be higher than what is earned by employment (benefit trap). Moreover, there are the extra costs of going to work such as child care or transportation and there may be an "implicit tax" as labor force participation can result in the loss of beneficiary status and additional benefits such as housing supports (Cook, 2006; McQuilken et al., 2003; Secker & Gelling, 2006). In addition, due to the cyclic nature of mental disorders, people with mental health problems may regularly experience an outburst of symptoms in which case they may want to decrease work time or take a break. Yet, there is a lack of a clear policy on this and after a return to work many are confronted with maladapted systems (Bond & Drake, 2014; Noble, 1998). For example, when people started to work but became ill again, the person may be confronted with financial insecurity as the process to become a disability receiver may start from zero or takes a lot of time. This will demotivate people to even try to work. More knowledge is needed on how disability policies can be reformed in order to motivate people with SMI to work (Harvey et al., 2013; Taskila et al., 2014).

Besides ineffective policies, stigma is both an indirect and a direct cause of discrimination of people with SMI (Bond & Drake, 2014; Cook, 2006; Thornicroft, 2009). First, it is an indirect cause due to policy neglect and historical patterns of structural disincentives against competitive employment (Stuart, 2006). Second, it is a direct cause of employment discrimination due to the prejudicial attitudes of employers and colleagues (Bezborodovs & Thornicroft, 2013; Kaye, Jans, & Jones, 2011; Lanfredi et al., 2014; Tsang et al., 2007). Employment is one of the most frequent reported areas of perceived and anticipated discrimination by people with schizophrenia or depression (Lasalvia et al., 2013; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). This may inhibit them to apply for jobs or show up on job interviews. Although the role of employers is increasingly studied (Gilbride, Stensrud, Ehlers, Evans, & Peterson, 2000), more research is needed on how employers can be convinced and supported to hire people with SMI. In addition, it is important to study new approaches to prevent and tackle stigma (Taskila et al., 2014).

In the case of Belgium, the well-developed unemployment and disability benefit system is very complex and many inconsistencies exist (OECD, 2013a). The Belgian labor law is also still too strict concerning part-time work as it is difficult to gradually increase the number of working hours. The minimum duration of part-time work is also one third of a full-time job, often too much for people with complex disorders. More studies on what people with SMI need and wish is desirable in order to create policy regulations that contribute most to the employment of people with SMI. Moreover, no

research exists on which barriers Belgian employers, families and friends perceive and how they can be stimulated to support people with SMI.

3.3.2 The meso level: services

A second way to improve employment outcomes is to tackle meso-level hurdles, e.g., (1) availability and quality of programs, (2) counselors' skills and job support, and (3) attitudes of counselors.

A. Availability and quality of programs

Many people with mental illness receive few or no employment services (Cook, 2006). In addition to few people with SMI receiving employment services, many do not receive adequate clinical services as well (Cook, 2006; Delespaul et al., 2014; Van Veldhuizen, 2006). This implicates that the offer of integrated services will not be optimal as well. This is a major problem as integration between both services is associated with superior employment outcomes. Non-integrated services are less effective because of the fragmentation, poor access, conflicting messages and inadequate communications between providers. These services are often present due to the way employment and health care structures are organized (Frost, Morris, Sherring, & Robson, 2010; Harvey et al., 2013). In contrast, integration makes it possible for the client to relate to a single team of counselors who provide a consistent message.

When people want a competitive job and they do receive some employment services, these are often not high fidelity IPS programs. Nevertheless, high fidelity implementation of IPS-principles is necessary to attain high competitive employment outcomes (Becker, Smith, Tanzman, Drake, & Tremblay, 2001; Gowdy, Carlson, & Rapp, 2004). Implementing such high fidelity IPS programs is not straightforward due to factors such as funding problems, insufficient time for program leaders, and inadequate co-operation between the involved organizations (Fioritti et al., 2014; Marshall, Rapp, Becker, & Bond, 2008; van Erp et al., 2007). Important factors when implementing IPS is the commitment of vocational team members, their skills (e.g., job searching, contacting employers…) and the integration of vocational and mental health staff.

Concerning the Belgian VR context, it is not known if there are any (high-fidelity) IPS programs or which evidence-based principles are currently implemented. Regarding the integration between mental health and VR services, little integration can be expected as employment and mental health policies are responsibilities of different governmental departments. Although collaboration seems to increase due to new reforms, the OECD keeps advising Belgium to increase the co-operation

between the VDAB and the mental health sector (OECD, 2013b). It is vital to study which barriers hinder the implementation of IPS, which reforms are needed to tackle barriers and how collaboration can be improved (Becker et al., 2001; Becker et al., 2006; Harvey et al., 2013).

B. VR counselors' skills and job support

An increasing number of studies show that the person of the VR counselor -and the mental health practitioner as well- plays an important role to achieve high competitive employment outcomes (Drake et al., 2006; van Erp et al., 2013). It is essential that counselors are able to use a client-centered approach and to build contacts with employers in the community (Corbière, Brouwers, Lanctôt, & Van Weeghel, 2014; Michon, Van Weeghel, Kroon, & Schene, 2005). Moreover, they need to have sufficient contacts with the service user (Corbière et al., 2014; Van Weeghel et al., 2005). Although knowledge is increasing, more studies on the skills of counselors and on the effects of trainings are needed (Taylor & Bond, 2014). Approaches to improve job development skills can include training programs to approach employers, field mentoring or group supervision (Becker et al., 2007; Carlson & Rapp, 2007). These approaches need to be combined with interventions that address (specific) job-related problems, e.g., errorless learning on the job site, cognitive training and using new multimedia techniques (tablet computers, direct client data entry and learning communities) (Haslett, McHugo, Bond, & Drake, 2014; Lord et al., 2014; Taskila et al., 2014).

C. VR counselors' attitudes

Besides the level of skill, it is now known that attitudes of counselors and supervisors influence employment outcomes as well (Catty et al., 2011; Gowdy, Carlson, & Rapp, 2003; Taskila et al., 2014). When they hold low expectations regarding competitive employment of people with SMI (Harris, Matthews, Penrose-Wall, Alam, & Jaworski, 2014), they will be less likely to focus on such jobs (Marwaha et al., 2009; Pirttimaa & Saloviita, 2004; Social Exclusion Unit, 2004). Therefore, recent overviews of the challenges of VR in general and IPS in specific, highlight the necessity to study the attitudes and intentions of both mental health and VR counselors (Drebing et al., 2012; Mueser & McGurk, 2014).

In Belgium, no formal academic training for VR counselors exists. The VDAB offers internal trainings for its own employees and those of the GTB and GOB. These latter organizations also offer more specialized internal trainings. This diversity of trainings and workshops makes it very difficult to assess which evidence is presented to students and counselors, which skills are trained and how these affect attitudes and employment outcomes.

3.3.3 The micro-level: the person with SMI

In addition to barriers on the macro and meso level, there are some barriers on the level of the person with SMI such as a lack of necessary education, illness-related barriers, or loss of work productivity.

People with SMI risk an interrupted or unfinished high school and postsecondary education and training due to the early onset of many mental health problems. At late adolescence, a fifth of the adolescents have experienced a severe episode of mental health problems (Ormel et al., 2014). Moreover, about 10% of all youth have poor mental health and may be at risk of long-term mental illness in adulthood (Ormel et al., 2014). When problems arise, it may implicate that they (temporarily) need to discontinue their education. Yet, (advanced) education is increasingly essential to securing a valued and high-paying job (Cook, 2006). Not only education, but finding and holding a competitive job can be hindered by illness-related barriers such as cognitive deficits or co-occurring physical health problems (Becker, Whitley, Bailey, & Drake, 2007; Razzano et al., 2005; Salkever et al., 2007). Symptoms can lead to some form of decreased productivity at work (Dewa, Corbière, Durand, & Hensel, 2012) and there is often absenteeism and presenteeism (to continue to work despite having symptoms) (Chong, Vaingankar, Abdin, & Subramaniam, 2013).

The often mentioned 'lack of motivation' is in many cases a symptom of the illness although it can be a result of medications used to alleviate symptoms as well (Alverson, Carpenter, & Drake, 2006; Thomas & Kalucy, 2003). Furthermore, a lack or loss of motivation can be associated with the prolonged absence from the workplace and its subsequent feelings of shame, a lack of confidence or experienced stigma (Corbière, Mercier, & Lesage, 2004; McQuilken et al., 2003; Secker et al., 2001). Going further on the latter, self-stigma is relatively common among people with SMI. Stigmatizing views of the own person about himself can decrease hope and self-esteem and can in turn increase avoidant coping, active social avoidance and depressive symptoms (Lanfredi et al., 2014; Taskila et al., 2014; Yanos, Roe, Markus, & Lysaker, 2008). Anticipated and experienced stigma will withhold the person to look for a job (Lasalvia et al., 2013; Thornicroft et al., 2009).

The illness-related barriers, a lack of education and loss of work productivity can have a negative effect on the goals that people set and on the chances to find a job (Yanos et al., 2008). Yet, some of these barriers can be bypassed by implementing high-fidelity Supported Employment and Supported Education programs (and thus close collaboration with clinical services and job-carving). To help even more people to overcome barriers to employment, more research is needed on new medications, medication management and cognitive behavioral methods (e.g., stress management) (Henry, 2004; Secker, Grove, & Seebohm, 2001). Several other approaches to address barriers include motivational

interviewing and shared decision-making (Drake, Deegan, & Rapp, 2010; van Erp, Michon, van Duin, & Van Weeghel, 2013). Moreover, IPS is mostly offered to people suffering from SMI, but other populations may profit from the IPS principles as well, e.g., young people during the early phases of schizophrenia or individuals with a criminal background and multiple difficulties (Drake & Bond, 2008; Frost et al., 2010).

In Belgium, we hardly know what people with SMI prefer and how barriers and motivation affects employment rates. For this, Belgian researchers commonly rely on international evidence. Nevertheless, the Belgium context partly differs from other countries due to Belgium's high number of psychiatric beds, lower number of community-based services, high protective welfare and its tradition to focus on Sheltered Employment.

4. Stakeholders in the VR process

In the previous section we focused on the challenges in order to increase competitive employment rates and improve non-vocational outcomes. It became clear that durable competitive employment can be achieved by the collaboration between diverse stakeholders, i.e., the person suffering from mental health problems, VR counselors, mental health practitioners (e.g., psychiatric nurses psychologists, social workers), employers (and colleagues), family members and friends and policy makers.

Based on the needs reported in research and practice, we will focus on the VR counselor, hospitalized patients with mental health disorders and their mental health practitioners. The rationale behind this is that these three actors highly influence the VR process, especcially at the start of the VR process. The **first stakeholder** is the person with mental health disorders (Figure 8). In the case a person receives treatement or is hosptilalized, it is important that the **second stakeholder,** the mental health practitioner, pays attention to the person's vocational needs and goals. This may contribute to a stronger interpersonal attachment which is reflected in better future working alliances with the VR counselor (Catty et al., 2010; Catty et al., 2011). Moreover, the mental health practitioner needs to work closely with the VR counselor, the **third stakeholder** (double arrow in figure 8).

In an ideal situation, both professionals work in an integrated team but this is often not yet present in Belgium. Thus, if a mental health practitioner is not keen to focus on employment or does not contact the VR counselor, prolonged periods without VR support can be expected. In the case a

person does not receive mental health treatment and care but receives VR services, the VR counselor can create a link -if needed- with mental health services.

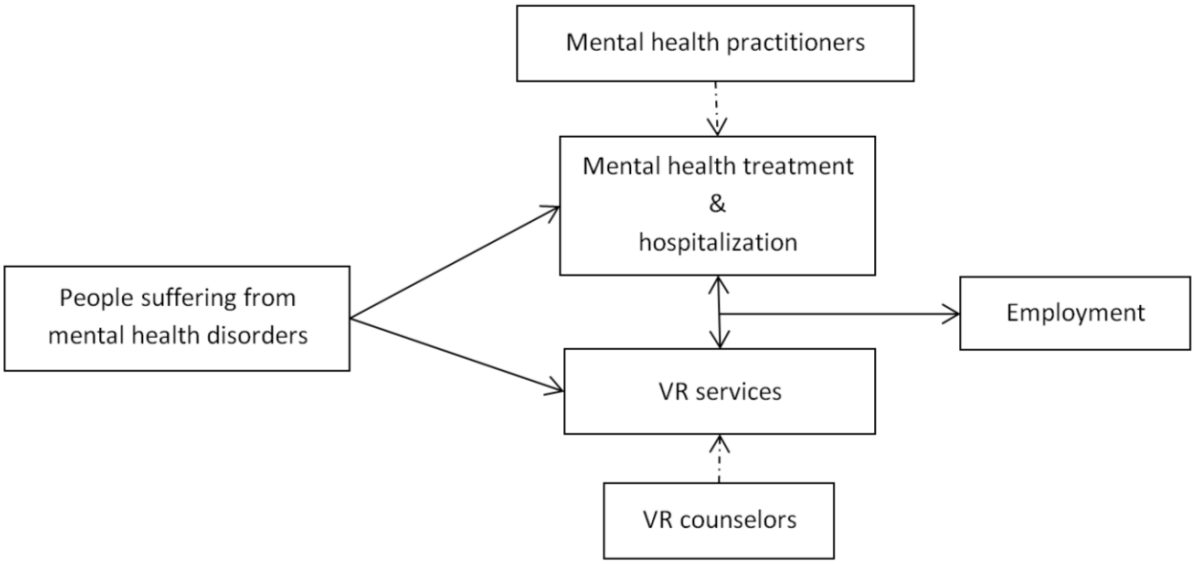

Figure 8. Link between mental health services and VR services in Belgium

By describing the VR process like above, it becomes clear that competitive employment outcomes can only be expected when the patient has a competitive job interest and when both professionals are skilled, supportive and motivated to help the person with mental health problems to find and keep a job.

By chosing these three stakeholder, we do not include employers (and colleagues), family members and friends and policy makers. It would be interesting to focus on each of these actors independently and on the interplay between them. Yet, because we opt for in-depth qualitative and quantitative studies, one doctoral study can not include all actors. We did not chose to focus on employers because they are often involved in latter phases and their hiring intentions are partially influenced by other involved professionals (mental healht practitioners and VR counselors). As long as a clear view on these professionals' skills and attitudes is lacking, recommendations to stimulate employers may be only partially successful. We did also exclude policy makers from the research. Their views, governemental decisions or policies would be interesting to include in sociological or judicial studies. Concerning family members and friends, there is increasingly more evidence that they hold an important role. Although not addressed in this study, we support research comprising this group.

The next paragraph will elaborate more on how the three chosen stakeholders can influence employment outcomes by reporting current knowledge and stipulating research gaps.

4.1 The professionals

4.1.1 Attitudes towards mental health problems

The attitudes of the general public towards people with SMI can be quite negative (Nordt, Rössler, & Lauber, 2006; Stuber, Rocha, Christian, & Link, 2014; Taskila et al., 2014). The same negative attitudes can be held by nurses, psychologists or psychiatrists, irrespective of their volitional choice to work with the target group (Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Stuber et al., 2014; Wahl & Aroesty-Cohan, 2010). Such negative attitudes can vary from a "laisser faire" attitude to even open hostility (Rapp et al., 2010). It seems that professionals may perceive people with SMI as dangerous, unskilled, unreliable or disturbing social life due to a lack of control of emotions (Ahmead, Rahhal, & Baker, 2010; Lauber, Nordt, Braunschweig, & Rössler, 2006; Stuber et al., 2014). The fact that negative attitudes exist among trained professionals shows that working with the target group and daily contact are not enough to counter stigma (Ahmead et al., 2010; Nordt et al., 2006). In settings of psychiatric hospitals, even lower expectations than the general public can exist due to a bias as a result of multiple confrontations with readmissions and severe symptomatology (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999).

4.1.2 Attitudes towards the employment of people with SMI

Until recently, many mental health programs held a medical perspective of sickness and disability and practitioners were less involved in rehabilitation and integration into the community (Drake & Bond, 2008). The consequence is that mental health practitioners find employment not a (clinical) priority and that they think VR services need to be offered outside the clinical context or psychiatric hospital (Taskila et al., 2014). This is a major issue as the integration of vocational and mental health staff is an important lever to high employment outcomes (van Erp et al., 2007).

The fact that it was often perceived as no responsibility of clinical practitioners is shown in the underrepresentation of employment themes in research on professionals' attitudes and goals (Marwaha, Balachandra, & Johnson, 2009). Luckily, a growing amount of research is now focusing on employment and on the role of the mental health practitioner. Evidence from these studies suggests that mental health professionals hold negative and even unhelpful attitudes with respect to the employment of people with SMI. Although most mental health practitioners perceive that more people with psychosis are capable of working then are currently at work, many consider about two thirds of their own clients not capable for competitive work (Marwaha et al., 2009). These attitudes and expectations are often the result of concerns and misbeliefs. For example, practitioners often think that their patients are not interested in work, do not have the proper skills (Henry, 2004;

Marwaha & Johnson, 2005) or hold unrealistic work expectations (Becker, Drake, Farabaugh, & Bond, 1996). Especially counselors of inpatient settings perceive people with SMI as less trustworthy and less capable of acquiring or maintaining a job (Hugo, 2001). Another misbelief is that competitive employment will cause deterioration in mental health and will consequently increase the risk for relapse and re-admissions (Marwaha et al., 2009; Roberts, 2003). Such deterioration in mental health is presumed to be the result of the high expectations and demands on the regular work floor (Hugo, 2001; Lauber et al., 2006; Marwaha et al., 2009; O'Brien, Price, Burns, & Perkins, 2003). In contrast with these beliefs, competitive employment is not associated with an increase in for example psychotic symptoms (Burns et al., 2009).

The lack of recognition of employment as an attainable and important outcome can be detrimental. Mental health practitioners can unintentionally deliver hopeless messages and inaccurate advice, such as that medication use will be life-long and employment is not yet or no longer relevant (Drake & Bond, 2008; Secker et al., 2001; Secker & Gelling, 2006). Notwithstanding the many concerns of counselors, they do perceive some benefits as well. They find work a tool to increase confidence and self-esteem and find that it may offer a daytime structure and an opportunity to meet other people outside the inner circle of friends and family. Other advantages include financial gain and reduced substance misuse (Marwaha et al., 2009).

4.1.3 VR counselors' specific influence on employment outcomes

Besides the mental health practitioner, the VR counselors' attitudes, expectations, skills and behavior impact the employment rates of VR programs as well (Gowdy et al., 2004; Mueser & McGurk, 2014; Taskila et al., 2014).

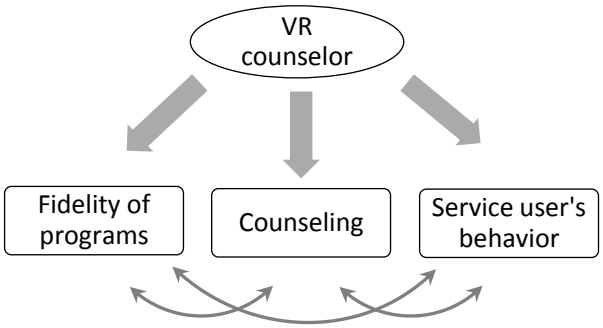

Figure 9. Counselors' influences on employment outcomes

Effect on the fidelity of programs. Employment rates for high-fidelity IPS programs are higher than for low-fidelity programs (Gowdy et al., 2003). To attain such high fidelity, VR counselors must agree with the evidence-based principles and need to adhere to them in daily practice (Beyer, Jordan de Urries, & Verdugo, 2010). Yet, not every VR counselor supports all IPS principles, and especially the focus on competitive jobs is often questioned. When implementing evidence-based models, it is important that supervisors hold positive attitudes and stimulate counselors to do the same. Supervisors need to intensively supervise and train their VR counselors (Marshall, Rapp, Becker, & Bond, 2008; van Erp et al., 2007). Paying attention to these factors will increase the likelihood of high-fidelity programs which in turn will result in high competitive employment outcomes (Rapp et al., 2010; van Erp et al., 2007).

Effect on counseling behavior. VR counselors' attitudes do not only affect the implementation of evidence-based principles, they also influence employment rates more directly. This became evident when comparing successful and less successful IPS services. Supervisors of successful VR services emphasized that everyone can work (as long as the person wants it), that work is an important life goal and that integration into society has positive effects (Gowdy et al., 2004). Consequently, the counselors paid more attention to the strengths, desires and work interest of customers. Moreover, they saw stigma or a lack of knowledge in society about SMI not as insuperable barriers to employment (Gowdy et al., 2004). In contrast, in less successful programs counselors expected that patients will hold competitive jobs less long (Harris, Matthews, Penrose-Wall, Alam, & Jaworski, 2014). Enthusiastic counselors lost their enthusiasm fueled by doubts and resistance of less motivated counselors. Low outcomes were also reported when counselors perceive that hygiene, substance use and social skills need to be of a good standard before starting the job search (Marshall et al., 2008).

Perceptions and attitudes thus affect the quality of services and the goals that are set by counselors. Counselors with negative attitudes and perceptions will focus less on a quick search for jobs which results in lower employment outcomes (Marwaha et al., 2009; Pirttimaa & Saloviita, 2004; Social Exclusion Unit, 2004; Taskila et al., 2014).

Effect on patients' goals and behavior. Perceptions and attitudes of counselors also affect the working alliance between the counselor and the job seeker (Marwaha et al., 2009; Pirttimaa & Saloviita, 2004; Social Exclusion Unit, 2004). People who experience negative attitudes and a low motivation of the counselor are more likely to drop-out (Sirey et al., 2001) with the result that they are less likely to find jobs. People with schizophrenia are for example more often employed when their counselors have positive expectations about their internal resources to handle barriers and communicate about their hope. Yet, when their counselors have higher expectations about specific valued social roles (i.e., ability to have a career, be a community leader, take classes) people tend to

be less employed. One explanation for this unexpected finding is that counselors with high social expectations send too intrusive signals to the person (O'Connell & Stein, 2011).

4.1.4 Research gap

By increasing our knowledge concerning the different professionals involved in the VR process, it becomes possible to create more effective trainings and to attain better employment outcomes.
Until now, few studies assessed mental health practitioners and VR counselors' attitudes, beliefs and intentions concerning the VR of people with SMI. It was often regarded as less important for mental health practitioners to be involved in the VR process. Yet, studies show that they do hold an important role.
For VR counselors, an increasing body of evidence shows the importance of specialized skills and positive attitudes towards competitive employment. An overall framework of their intentions to focus on competitive employment, incorporating more variables than merely attitudes or barriers, is still lacking. Although most research focuses on attitudes or barriers, more important determinants may play a role as well (e.g., social norms, self-efficacy, prior experiences). Hence, more research is needed on a framework that can explain counselors' intentions or behavior (Drebing et al., 2012; Goscha, Kondrat, & Manthey, 2013).

4.2 People with mental health problems

It is commonly acknowledged that care needs to be individualized, i.e., it needs to be adapted to the needs and goals of the person for whom it is intended. For this, the patient needs to be actively involved and all involved parties need to create a 'common ground' (Anthony, Ellison, Rogers, Mizock, & Lyass, 2014).
In the case of the VR process of people suffering from mental disorders, it is important that the VR counselor elaborates on the goals and needs of the job searcher. This means that he assesses what motivates the job seeker, which barriers to employment exist and which support may help. This information needs to be gained in the beginning of the counseling process and needs to be updated regularly. In the case of countries with longer hospitalization periods and few community-based services, the VR process may be initiated at the psychiatric ward. This can be positive as addressing the vocational needs and goals in early stages of recovery may contribute to a strong interpersonal attachment and a shared commitment to the goals and the steps to reach these goals (Bordin, 1979;

Lustig, Strauser, Rice, & Rucker, 2002). Starting the VR process earlier can also raise hope as professionals show their positive expectations regarding the future of the client (Rinaldi et al., 2008).

4.2.1 Do they want to work?

An important factor determining the success of IPS programs is the motivation of the person to work. Almost all scientific articles or project reports on IPS start with the statement that most people with SMI want a competitive job (McQuilken et al., 2003; Mueser, Salyers, & Mueser, 2001; Rinaldi et al., 2008). This statement is based on approximately 15 different studies of a qualitative or quantitative design. One of the most cited studies to support this statement is the Massachusetts survey of Rogers (1991). In this study, adults with a long-term mental illness were asked whether or not they would like to change their employment status. Of those who were not employed, 71% wanted to become employed and cited a specific work situation (Rogers, Walsh, Massotta, & Danley, 1991). Other studies found comparable percentages of 60 to 90% of people who want help with obtaining jobs, who are interested in (full or halftime) jobs or who want to become (self-)employed in the short term (Coursey, Farrell, & Zahniser, 1991; Frounfelker, Wilkniss, Bond, Devitt, & Drake, 2011; Van Audenhove & Wilmotte, 2004).

The abovementioned statement that most people with SMI want to work is now regarded as a fact. Yet, studies that are less often cited find a vocational interest rate of 36% or less (McQuilken et al., 2003; Secker & Gelling, 2006). This can be partially explained by the fact that an important limitation in the studies with high vocational interest is that they mostly consider the vocational interest of people already participating in VR programs (Becker, Bebout, & Drake, 1998; Becker et al., 1996; Macias, DeCarlo, Wang, Frey, & Barreira, 2001) or with an a priori interest in competitive employment (Mueser, Becker, & Wolfe, 2001).

In sum, vocational interest is high among many people with SMI and their motivation is indeed crucial to attain high competitive employment outcomes. Yet, vocational interest may be currently overestimated. It is important to study the vocational interest of other groups of people suffering from SMI, e.g., those not already participating in VR programs or those with a criminal record. In addition, if motivation seems lower in these groups, studies need to focus more on how to increase vocational interest.

4.2.2 Consensus

In addition to solely assessing and documenting patients' goals, it is important that counselors and patients reach consensus on which goals will be the focus of the counseling, on the barriers to

employment that exist and on the course to follow in order to overcome barriers (Crane-Ross, Roth, & Lauber, 2000; Taskila et al., 2014; Tryon & Winograd, 2011).

In the case of hospitalized people, this process can already be started by the clinical key worker (mental health practitioner of the psychiatric ward). This is important as by involving the client in his vocational future, the clinical counselor offers a sense of hope and a feeling of control (Anthony, Ellison, Rogers, Mizock, & Lyass, 2014; Hogue, Dauber, Dasaro, & Morgenstern, 2010; Strecher et al., 1995). Finding a consensus shapes future treatment plans and it indirectly affects subsequent therapeutic relationships and even treatment outcomes (Catty et al., 2010; Tryon & Winograd, 2011). Yet, work may not be perceived as an important outcome by mental health practitioners (Taskila et al., 2014). Therefore, we assume that many counselors and their patients have different perspectives.

4.2.3 Research gap

There is an increasing emphasis on implementing evidence-based practices and on the incorporation of patients' preferences in the provision of services. Until now, most research on vocational rehabilitation focused on people with a psychotic disorder or patients who are no longer hospitalized. Yet, to avoid prolonged unemployment after hospitalization, VR can begin during hospitalization. This is especially important in countries with higher hospitalization rates and longer average stay at hospitals. It is not known which vocational goals are held by hospitalized patients and support may thus be inadequate.

To plant the seed for more successful VR after (and during) hospitalization, it is important that mental health practitioners on the ward help the patient to identify vocational interests, barriers and support needed. They need to find some kind of agreement on goals, vocational barriers and necessary rehabilitation steps to overcome barriers. There are many studies concerning differences between patients' and mental health practitioners' attitudes and expectations, but few studies exist for matters relating to employment. We do assume that incongruences occur as work is often not perceived as an important clinical outcome (Taskila et al., 2014).

Chapter 2

Objectives and methods

The previous chapter concluded with a literature overview concerning three stakeholders of the vocational rehabilitation (VR) process (i.e., the patient, the mental health practitioner and the VR counselor). In this chapter, we briefly repeat current research gaps before describing which research questions will be addressed in this doctoral project.

1. Research gaps

When someone suffers from (severe) mental illness (SMI), it may be necessary to receive specialized services and treatment while being admitted to a psychiatric hospital. During hospitalization, it is important that professionals stimulate the individual to have a look at important domains of life. Patients can then formulate a rehabilitation plan that will stimulate recovery.
One of the important topics that need to be addressed early in treatment is employment. The Individual Placement and Support (IPS) model of Supported Employment is effective in decreasing prolonged unemployment of people with SMI and thus minimizing the risk of negative experiences. Implementing IPS implicates that professionals for example (i) work with patients' preferences, (ii) make work of a quick job search, and (iii) focus on competitive employment. It also implicates that VR counselors are integrated in the mental health team.

In sum, mental health professionals need to create a strong alliance by working with patients' preferences, assessing vocational goals and supporting the patient when facing barriers. This can in turn positively influence the subsequent relationship with the VR counselor. This VR counselor must be contacted when the person wants to find a competitive job as he is an expert in supporting the competitive job search, contacting employers and adapting jobs in function of the person's strengths and limitations (job carving).
This process of the collaboration between different stakeholders (i.e., patients, mental health practitioners and VR counselors) is depicted in figure 10.

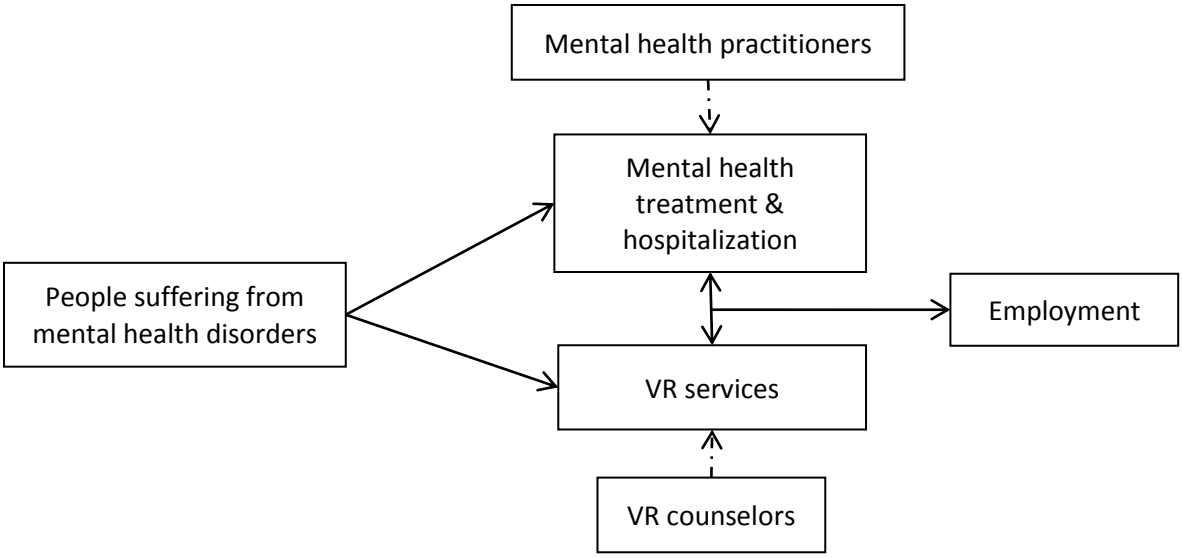

Figure 10. Link between mental health services and VR services in Belgium

Within IPS and the process of collaboration, some situations may negatively affect competitive employment rates, e.g. (Cook, 2006; Marwaha, Balachandra, & Johnson, 2009; Marwaha & Johnson, 2005; Secker, Grove, & Seebohm, 2001):

- professionals may perceive patients as not motivated for competitive employment
- patients and mental health practitioners may have different perspectives concerning employment related topics (vocational goals, barriers, support that will be needed…). They do not find a consensus
- the VR counselor may not be motivated to focus on competitive employment for people with SMI

Yet, as addressed in the research gaps in the previous chapter, many questions remain:

- Previous studies focused on vocational goals of people that were not hospitalized. It is not known which vocational goals are held by hospitalized patients.
- Many studies report differences between patients' and mental health practitioners' attitudes, preferences and needs on diverse topics, but few studies focus on the vocational life domain (Taskila et al., 2014).
- There is need for more research on a framework that explains VR counselors' intentions to focus on competitive employment as an overall framework is still lacking (Drebing et al., 2012; Goscha, Kondrat, & Manthey, 2013).

2. From research gaps to studies

This doctoral project aims to increase knowledge and to contribute to more effective VR services. In the first research part, we focused on hospitalized patients and their mental health professionals **(study 1)**. The second research part consists of two studies, respectively focusing on VR programs and VR counselors. An explorative study focused on the implementation of IPS and implementation barriers at different VR programs **(study 2)**. The results of this study were then used in a study comprising VR counselors of Flemish employment services **(study 3)**. Each of the studies is accompanied by one or two articles. The depicted figure shows how the articles are spread across the different research topics (figure 11).

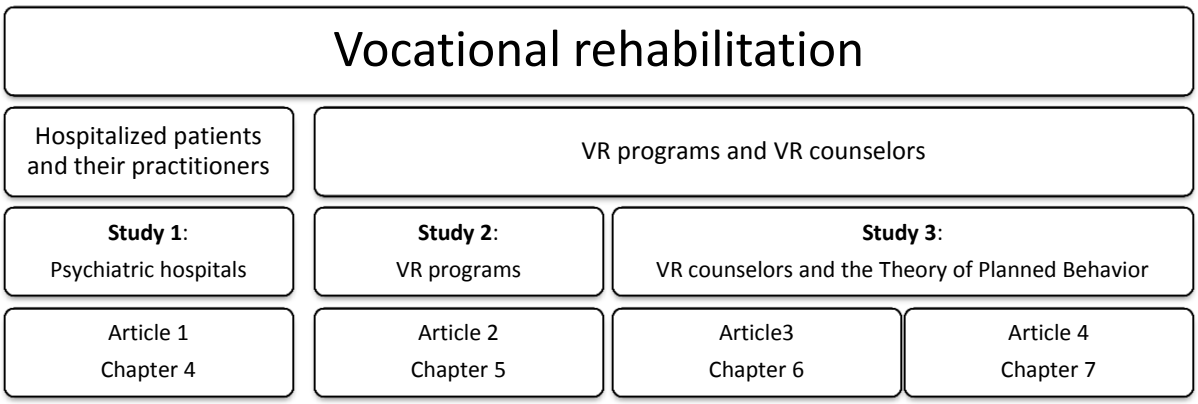

Figure 11. Overview of studies and articles

In the **first study (chapter 4)**, three research questions were addressed:

1) What are the vocational goals of hospitalized patients with mental disorders in the short and in the long term?
2) Which vocational goals do mental health practitioners perceive as realistic for their patients?
3) What is the level of agreement between patients and practitioners concerning: competitive jobs / employment barriers / steps to overcome barriers?

Population:

1) Patients suffering from (severe) mental illness:
    - People who are hospitalized and suffer from mental illness
    - Patients of the day activity center/Supported Housing are included as they are supported by psychiatric nurses or vocational therapists. This setting is regarded as an additional ward of the hospital.

2) Mental health practitioners

Method:

A cross-sectional survey design was used to study vocational goals of hospitalized patients of different psychiatric hospitals and centers at which people receive care from psychiatric nurses (i.e., Sheltered Housing and day activity centers). A questionnaire was developed in collaboration with practitioners and patients. One clinician group comprised 4 VR counselors, the other groups 3 vocational therapists and one psychologist. Patients of the patient groups were selected by their clinician and were hospitalized at different types of wards. In total, 14 patients were involved, if they were still hospitalized, they also received a questionnaire.

The questionnaire was distributed among hospitalized patients of different wards and their key mental health practitioners (paired data). Some practitioners filled in multiple questionnaires as they provided support to different patients. About 70% of practitioners filled in 3 or less questionnaires, three practitioners filled in many questionnaires (13, 16 and 21).

Patients indicated their short-term and long-term vocational goals while mental health practitioners indicated which goals are perceived as realistic in the short and long term. Moreover, patients and counselors indicated how many vocational barriers to employment they perceive and which vocational support is perceived to be needed to overcome these barriers. The associations between patients' preferences and practitioners' perspectives were studied using Chi^2-analyses, kappa and Cramers' V coefficients and McNemar-Bowker's test of symmetry. Binary logistic regression analyses were used to check for a link between patients' characteristics, their goals and practitioners' ideas.

In the **second study (chapter 5),** we answered research questions 4 and 5:

4) Do VR services implement IPS principles?
5) Which barriers to focus on competitive employment are experienced by VR services?

Population:

VR counselors of different vocational rehabilitation services that were believed to offer Supported Employment, Sheltered Employment or pre-vocational counseling.

Method:

Flemish VR programs were visited and a translated version of the IPS Fidelity Scale was administered. The IPS Fidelity scale helped to assess how many evidence-based practices are implemented by a VR program. The fidelity scale consists of four factors, i.e., Job selection,

Integration with treatment team, Job development and Vocational staffing. Each factor consists of multiple items, 15 in total. For each item, the rater (the researcher) poses a question that allows him/her to rate the answer. To score a single item, the rater must choose which predefined score (1-5) fits best with the answer given during the interview (see example). The total score ranges from 15 to 75, scores between 66 and 75 indicate high implementation of IPS, scores between 56 and 65 fair implementation and scores below 55 no implementation.

Example: item 'caseload'

Employment specialists manage caseloads of up to 25 consumers.

1. A ratio of 81 or more consumers per employment specialist, or 'Cannot rate due to no fit'
2. A ratio of 61 to 80 consumers per employment specialist
3. A ratio of 41 to 60 consumers per employment specialist
4. A ratio of 26 to consumers per employment specialist
5. A ratio of 25 or fewer consumers per employment specialist

In addition, semi-structured interviews with VR counselors of different programs enabled the researchers to study the barriers to implement IPS and to focus on competitive employment. For this, the researchers first explained the IPS principles after which barriers and facilitators on different levels were assessed. The interviews were analyzed using thematic analyses and a code book based on prior international literature concerning implementing IPS services.

The **third study (chapters 6 and 7)** was set up to answer two final research questions:

6) Which factors determine counselors' intentions to focus on competitive employment?
7) What are the differences in underlying beliefs between counselors of different organizations?

Population:

VR counselors of the three major organizations responsible for VR (VDAB, GTB and GOB)

Method:

A theory-driven questionnaire based on the Theory of Planned Behavior was offered to VR counselors. The questionnaire was developed using input from a literature review of previous TPB studies, the international recommendations for measuring TPB-determinants and the results of the previous explorative study. To ensure face and content validity of the instrument, the questionnaire has been revised and adapted by an independent expert in constructing TPB questionnaires.

Data were analyzed using structural equation modeling. After checking the reliability and validity of the measurement model, a full model was tested and adapted. Model adaptations were made based on modification indices and theoretical assumptions. Using Analysis of Variance (ANOVA) and post hoc analyses, it was checked whether and how beliefs of counselors of the three organizations differ.

Because a major part of the manuscript concerns the Theory of Planned Behavior, we describe it in chapter 3.

Chapter 3

The Theory of Planned Behavior

A major part of our research focused on increasing knowledge concerning vocational rehabilitation (VR) counselors' intentions. The researcher chose to use an a priori theoretical framework as the basis for data-collection in order to theoretically guide the answering of the research questions. This way of working is useful when specific measures of constructs need to be developed (Glanz & Bishop, 2010).

A literature search was conducted to explore theories that make it possible to explain or predict behaviors, i.e., why some counselors may be more intended to focus on competitive jobs compared to others. This search had a broad scope covering theories explaining people's behavior and intentions, the rehabilitation of people with severe mental illness (SMI) and vocational rehabilitation (VR) programs. Ultimately, the Theory of Planned Behavior (TPB) was chosen as the guiding theoretical framework. Before explaining why the TPB was chosen by elaborating on some pros and cons, a brief summary of the theory is offered in the next section.

1. Core concepts of the TPB

The predecessor of the TPB is the Theory of Reasoned Action (TRA) that was formulated by Ajzen and Fishbein in the 1980's. The TRA aims to predict an individual's intention to engage in a behavior at a specific time and place. The theory was intended to explain behaviors over which people have the ability to exert some self-control (Madden, Ellen, & Ajzen, 1992). Because other factors in addition to one's intentions can determine whether or not the behavior can be performed, the concept of Perceived Behavioral Control (PBC) was added. PBC is hypothesized to be associated with both intentions and behavior. After including PBC, the theory is referred to as the Theory of Planned Behavior. Both TRA and TPB assume that human beings are basically rational and make use of available information when making decisions. Yet, TPB-protagonists do not think of human behavior as something that is always preceded by an extensive period of conscious deliberation about all positive and negative consequences, feelings and beliefs. It can be thus more subtle. To account for more habitual or emotional driven behaviors, researchers sometimes include corresponding variables.

The key components of the TPB model are behavior and behavioral intentions. Intentions are presumed to be influenced by (i) attitudes, (ii) subjective norms and (iii) perceived behavioral control. Each of these concepts can be measured on an overall level and on a 'belief-level' (Figure 12).

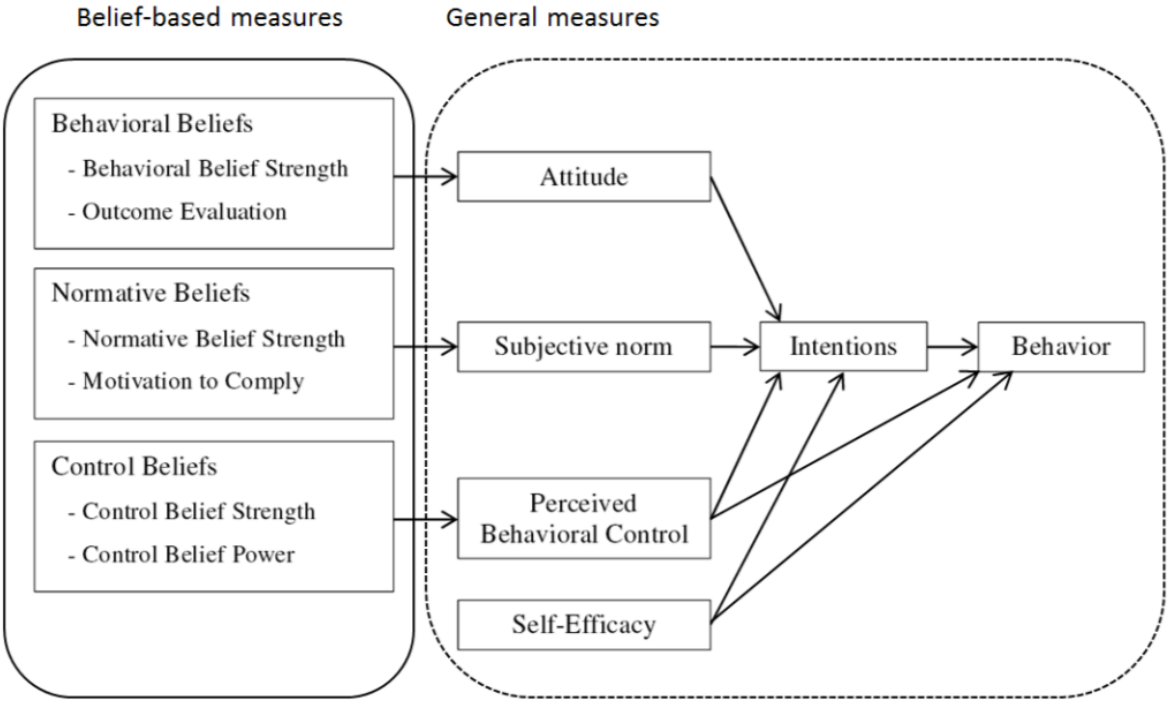

Figure 12. Theory of Planned Behavior (with self-efficacy) (Ajzen, 1991)

Attitudes are the individual's overall evaluation of the outcomes of performing the behavior (Ajzen, 1991; Fishbein & Yzer, 2003; Yzer, 2011) and they indicate a person's general feeling of favorableness towards the behavior (Ajzen & Fishbein, 1980). Attitudes are a function of (1) behavioral belief strength, and (2) outcome evaluation. Behavioral belief strength is defined as the perceived probability that an outcome such as more income, less stress… occurs. Outcome evaluation refers to how positive or negative each outcome is perceived, it is a rating of the desirability of the outcome (Ajzen, 2002).

Example: A person may believe that competitive jobs will result in higher income (behavioral belief strength), and this may influence him to look for jobs. Yet, when the person believes that higher income is not very important (evaluation), he will be less likely to look for paid jobs.

Subjective norms refer to whether salient referents (important others) would approve or disapprove of performing the behavior (Ajzen, 1991; Yzer, 2011). Subjective norms are a function of (1) normative belief strength and (2) motivation to comply. Normative belief strength refers to the perceived approval or disapproval of important referents for the behavior in question. Motivation to comply concerns the level of motivation to (not) comply with the opinion of the referents.

Example: On the one hand a person may believe that her parents would like her to work while on the other hand her friends stimulate living a free and jobless life (normative beliefs). Because the person is more motivated to comply with her friends, she will be less motivated to look for a job.

Perceived behavioral control (PBC) refers to the individual's perception of control over performing the behavior of interest. If people feel they have little or no control over performing a behavior, they will be less likely to engage in the behavior. PBC influences both intentions and behaviors. The underlying control beliefs are characterized by (1) control belief strength and (2) control belief power (Shook & Bratianu, 2010; Terry & O'Leary, 1995). The first refers to the likelihood that barriers occur, while the latter refers to the extent to which a barrier hinders performing the behavior. If many barriers are perceived and they hinder performing the behavior, people are less intended to engage in a behavior.

Example: A person may know by experience that it is difficult to find a job because he makes a bad first impression (control belief strength). Although it is only one barrier, a bad first impression is disadvantageous for the person because he applies for a job as a salesman (control belief power). The person is thus less likely to look for and find a job.

Self-efficacy can be defined as a personal judgment of one's capabilities to organize and perform behaviors to attain goals and overcome barriers (Bandura, 1977; Shook & Bratianu, 2010). At first, self-efficacy was not an integral part of the TPB. Self-efficacy was increasingly added in studies due to a lack of effect of Perceived Behavioral Control on intentions and the need for a factor that also incorporates how people deal with barriers. Nowadays, it is often regarded as an integral part of the TPB as it is a strong predictor of intentions above the other TPB-components (Ajzen, 2002; Miller & Miller, 2011; Montano & Kasprzyk, 2008a; Povey, Conner, Sparks, James, & Shepherd, 2000).

Example: A person can find his bad first impression very hindering when applying for jobs. Yet, when the person feels that he can overcome this (solicitation training, help from a friend…), the person can become more inclined to look for a job.

2. Appraisal of the TPB

The TPB belongs to the top ten most used theories for understanding diverse behaviors and for implementing interventions (Glanz & Bishop, 2010). As any other theory, it has some cons and pros.

2.1 The cons

In spite of the advantages of using the TPB it is also susceptible to criticism. It is for example said that the TPB does not take into account the role of emotional, moral, environmental or economic factors. Moreover, some state that the TPB assumes that behavior is only the result of a linear decision-making process and it thus not considers a change over time (it for example does not account for variables such as past experience). Most of the criticism implies that more variables need to be added to predict a person's intentions with more success. Luckily, Ajzen stated that adding variables is possible when they are relevant to the behavior under study. Over the past several years, researchers have used the constructs of the TPB and added other components from other theories to make it a more integrated model (for example the Integrated Behavioral Model depicted in the appendices).

In addition, we would like to elaborate further on some of the abovementioned criticism. First, some researchers state that the TPB does not take into account the role of emotional, moral or ethical factors. The TPB is indeed fundamentally a social-cognitive model with most attention to volitional behavior and cognitions. Yet, emotions are partly captured in the belief-based measure of attitudes. This measure can include both instrumental (i.e., beliefs concerning a behavior's outcome) as well as affective/experiential beliefs (i.e., emotion-based judgments about the behavior and beliefs pertaining to the experience) (Bassett-Gunter et al., 2013; Lo, van Breukelen, Peters, & Kok, 2014). Moreover, the TPB is adaptable and there is an increased interest for the inclusion of emotions, ethics and moral norms (Kaiser & Scheuthle, 2003; Newton, Newton, Ewing, Burney, & Hay, 2012; Rivis, Sheeran, & Armitage, 2009).

A second criticism is that of the effect of prior behavior and habits. Some suggest that prior behavior is the major predictor of intentions and behavior (Ouellette & Wood, 1998; Smith et al., 2008). This can be the case when behaviors are performed often and do not require much volitional control, e.g., going for a walk with the dog at 7.30 pm. In these cases, the role of prior behavior can be so important that the other TPB-variables are primarily associated with prior behavior and not with intentions. Yet, studies show that prior behavior does not completely predict intentions and behavior and that the other TPB-variables remain important. This is especially the case in more complex social behaviors where more deliberate thinking is required such as situations in which general

practitioners need to help patients to decide which cancer treatment suits the person best. Besides, looking at past behavior will result in the same key question: "Which determinants affect someone's (past) behavior?".

A third reason why some researchers do not opt for the TPB is that many other models exist and they may offer more sufficient understanding of the behavior. Some relevant models are briefly explained in the appendices, e.g., the Attitude - Social Influence - Efficacy-model (ASE) (Vries & Mudde, 1998), the Health Belief Model (Jam and Becker, 1984), the Integrated Change Model (de Vries et al., 2003; Vries, Mesters, Steeg, & Honing, 2005) and the Integrated Behavioral Model (Montano & Kasprzyk, 2008b). As VR counselors' intentions were not yet sufficiently studied, the TPB offers a first and already profound insight of how intentions are formed. The TPB is superior to some of these other models as they may be too simple (ASE-model) or are less adapted to this context. The Health Belief Model for example incorporates variables that are less relevant for the behavior under study, e.g., perceived susceptibility to threat/disease or perceived seriousness. The Integrated Change Model is a valuable alternative for the TPB, but the literature concerning this theory is less extensive and no international guidelines to construct a questionnaire are present. Moreover, the amount of variables would result in a questionnaire that is too extensive and will demotivate VR counselors to complete it. Concerning the Integrated Behavioral Model (IBM), this model includes the TPB-variables and some other additional constructs (Montano & Kasprzyk, 2008). These additional constructs are presumed to affect behavior, but counselors' behavior is not easy to measure (due to the complex VR situation in Flanders with its many referrals, inconsistent regulations, long pre-vocational trainings…). As explained in the limitations of this doctoral project, future research need to study counselors' behaviors.

The researchers did choose some additional variables to create a TPB+ framework. In sum, we can speak of an extended TPB framework which closely resembles the Integrated Behavioral Model, except that some variables such as prior knowledge or environmental constraints were not withheld.

2.2 The pros

We used the TPB due to some benefits it has compared to other models. The TPB (i) is a well-researched model that is internationally accepted, (ii) is able to describe different types of behaviors, (iii) enables the researcher to create a context-specific framework, (iv) offers an in-depth understanding of the beliefs of respondents, (v) is open to adaptations and (vi) is easy to understand.

The TPB is a well-defined and scientifically sound theory for explaining behavior or setting up interventions (Glanz & Bishop, 2010). Different meta-analyses of the TPB-model have proven that the

TPB-variables are linked together and that they are related to intentions and behavior (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Armitage & Conner, 2001; Webb & Sheeran, 2006). Attitudes, subjective norms and PBC account for 39–42% of the variance in intentions, while intentions and PBC predict between 28 and 34% of the variance in behavior (Armitage & Conner, 2001; Rivis et al., 2009). Pre-posttests or randomized controlled trials showed that the TPB-variables can be manipulated and that they influence intentions and behavior (Giles et al., 2014; Jinnah, Stoneman, & Rains, 2014; Reid & Aiken, 2013).

The TPB was also selected as it is able to successfully explain and predict disparate phenomena including employment related topics. Employment related behaviors studied using the TRA and TPB include disclosing mental health problems to your employer, job searching or entering into self-employment (Brohan, Henderson, Slade, & Thornicroft, 2014; Kolvereid & Isaksen, 2006; van Ryn & Vinokur, 1992; van Hooft, born, Taris, & van der Flier, 2004). Kolvereid and Isaksen (2006) found that people's intentions and behaviors to start their own business could be explained using the TRA, but not the TPB. More specifically, beliefs of people influenced the overall TRA-variables (attitude and social norms) which in turn influenced intentions and behaviors. Even more interesting is the study of van Ryan and Vinokur (1992). In their intervention, unemployed people were offered a training to increase job-search self-efficacy. The intervention also aimed to foster positive attitudes and to offer social support. After both one and four months, participants of the intervention group were more likely to search for jobs and experienced higher levels of self-efficacy. In contrast, self-efficacy was not found to be an important predictor of job-search in the study of van Hooft, Born, Taris, and van der Flier (2004). They found that ethnic minority's perceptions of social pressures are related to job-search intentions while in the native group it are attitudes that are related to intentions. Even more related to our line of research is the study of Hergenrather, Rhodes, & McDaniel (2005) in which public rehabilitation counselors' intentions to focus on jobs for people with HIV proofed associated with three TPB-variables, attitudes, social pressures to perform the behavior, and impediments to and resources for performing the specific behavior.

In addition to the satisfactory level of scientific evidence, the TPB also enables more in-depth insight into the behavior under study. This is because it incorporates two levels of measures. On a more general level, the overall attitudes, social norms, perceived behavioral control and self-efficacy are measured. Investigating these broad constructs makes it possible to create a general framework explaining intentions of people. A second level includes belief-based variables which make it possible to study the beliefs regarding the consequences of a specific behavior, the perceived views of important referents or the effects of possible barriers. Studying these belief-based measures is not

very common in research, but enables us to generate a perspicuous picture of why people intend to (not) engage in a behavior. As a result, practical implications can be made and interventions can be tailored to the target group.

Another major advantage is that the TPB is open for additional variables when these variables are important for the behavior under study. Important variables already described in reviews of the TPB are for example prior behavior, self-efficacy or moral norms (Armitage & Conner, 2001; Conner & Armitage, 1998; Kaiser & Scheuthle, 2003; Rivis et al., 2009).

Lastly, the comprehensibility of a model may not be the primary reason to choose a model as it does not defines the scientific value of the model. Yet, high comprehensibility is helpful when retrieving practical implications for interventions. Moreover, when the topic under study was not yet fully investigated, the use of scientifically sound and comprehensible theories can improve the understanding and involvement by field workers and policy makers.

Chapter 4

Hospitalized patients and their practitioners

Perspectives of hospitalized patients with mental disorders and their clinicians on vocational goals, barriers and steps to overcome barriers

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* In the article, 'practitioners' are referred to as 'clinicians'

Perspectives of hospitalized patients with mental disorders and their clinicians on vocational goals, barriers and steps to overcome barriers

Abstract

Background. People with mental disorders experience difficulties with finding competitive jobs. In countries with longer psychiatric hospitalization periods, the vocational rehabilitation process can start during hospitalization. Yet, rehabilitation can be hindered by a lack of focus by clinicians on the patients' vocational goals and a lack of agreement between clinicians and patients.

Aims. To compare (i) vocational goals, (ii) barriers to employment and (iii) support needed to overcome barriers faced by patients.

Method. The paired data-set comprised 733 hospitalized patients and their 279 clinicians. Patients selected their vocational goals and clinicians indicated options that seemed realistic. Patients and clinicians indicated how many barriers exist and what support is needed to overcome barriers.

Results. Almost 45% of patients prefer competitive jobs, while 32% of clinicians find this realistic, indicating a moderate relationship between patients' goals and clinicians' perceptions. Patients and clinicians also differ in their perception of the level of barriers and types of support to overcome them. Patients perceive fewer vocational barriers than clinicians and prefer less intense vocational support options.

Conclusions. Patients and clinicians have different perspectives concerning vocational recovery. Improving vocational rehabilitation requires a stronger alignment between patients' and clinicians' vocational goals and barriers.

Keywords: vocational rehabilitation, hospitalized patients, clinician

Introduction

For many people with mental disorders participation in the community and in employment is an important aspect of their recovery process. Although they experience many difficulties with finding competitive jobs (OECD, 2012; Waghorn, Chant, & Jonsdottir, 2011), reviews of the Individual Placement and Support model (IPS) of Supported Employment provide evidence that competitive employment is realistic (Kinoshita et al., 2013).

Key elements of this evidence-based practice of IPS are the focus on competitive employment, quick job searches, collaboration with mental health services, and working with clients' job preferences (Becker & Drake, 1994). By focussing on these elements, clinicians foster hope, a feeling of control and involve the client as an equal partner. Consequently, it is more likely that goals are actually achieved and prolonged unemployment is decreased (Hogue, Dauber, Dasaro, & Morgenstern, 2010; Ryan & Deci, 2008). Thus, the involvement of clients in setting vocational goals and deciding on the process of how to achieve these goals must become a primary element of the early stages of rehabilitation (Anthony et al., 2014; Hogue et al., 2010).

Early involvement of people with severe mental illness (SMI) means that vocational rehabilitation (VR) can be initiated during hospitalization. This is especially important in countries where hospitalization rates are higher, hospitalization periods are longer and few community-based services exist.

At a psychiatric hospital, patients are supported by a mental health clinician. They are the patient's contact person, offer support and care and help the patient to develop a recovery plan. Ideally, this also includes assessing vocational goals, defining barriers to employment and pinpointing areas in which support is necessary (Harris et al., 2014). These activities are important because having knowledge of vocational goals and needs may stimulate the vocational progress (Rampton, Waghorn, De Souza, & Lloyd, 2010). However, mental health professionals often consider that employment-related questions fall outside the realm of their clinical services (Taskila et al., 2014). Consequently, the VR process often starts after hospitalization. When the patient has vocational concerns, delaying the VR process can have detrimental effects because a timely implementation of the process and a good working alliance with the mental health clinician indirectly affects subsequent relationships with the VR counsellor and employment outcomes (Catty et al., 2010; Tryon & Winograd, 2011). Not only delayed, but also ineffective VR support may contribute to negative experiences, thereby decreasing the likelihood of a positive VR outcome (Marwaha & Johnson, 2005).

Previous studies mainly focused on clients with SMI who receive care through community-based services. Little is therefore known about hospitalized patients. The aim of the article is to study (i)

vocational goals, (ii) barriers to employment and (iii) perceived ways to overcome barriers faced by hospitalized patients with mental disorders and their clinicians. The present study also sought to obtain information about potential differences in perspectives between patients and clinicians.

Method

The Belgian context

Belgium has the second-highest number of beds per capita in the world, with 179 psychiatric beds per 100,000 population (Samele, Frew, & Urquia, et al., 2013). Moreover, patients are often hospitalized for periods exceeding 10 weeks (Schoevaerts, Bruffaerts, & Vandenberghe, 2014; Umbach & Vanrillaer, 2014). At the time of the study, the Belgian mental health care context was characterized by an on-going reform process. More community-based services are being implemented and the number of psychiatric beds is decreasing.

Mental health clinicians are rarely trained in traditional or evidence-based VR practices. There exists a segregation of employment and mental health services and there remains a strong focus on Sheltered Employment (Knaeps, DeSmet, & Van Audenhove, 2012; Shima, Zólyomi, & Zaidi, 2008).

Participants

Self-developed questionnaires were completed by 733 (62%) of 1160 hospitalized patients, consistent with expectations. Patients were on average 42 years old (*SD*: 12.13, range 18-64y), and, according to the clinicians, 39% have multiple mental health problems (often a combination of psychotic symptoms and substance abuse or personality problems). Patients stayed at different types of psychiatric wards (long-stay, acute or in-patient day hospital programs) (93%). The remaining patients (7%) receive services of day activity centres (DAC) or Sheltered Housing. These patients were included as they receive intensive care by psychiatric nurses at locations owned by the psychiatric hospitals. Client characteristics are shown in Table 1.

Non-response analyses showed that, on average, non-responders were three years older ($t(967)$: 3.728, $p<.001$) than responders. Patients with psychotic problems were less likely to complete the questionnaire, but the opposite was true for those having substance dependence problems (χ^2:29.143, *df*: 6, $p<.001$). No differences exist concerning educational degree of responders and non-responders (χ^2:4.239, *df*: 5, *p*:.516).

The 279 participating key mental health clinicians, henceforth referred to as clinicians, are on average 38 years old (*SD*: 11.41, range: 20-61y, missing: 10) and most are women (*n*: 208, 76.5%, missing: 7). Clinicians work mostly as a psychiatric nurse (*n*: 194, 71%), occupational therapist (*n*: 32, 12%) or assistant-nurse (*n*: 19, 7%).

Table 1. Socio-demographic characteristics of the patient sample

Indicator	*n* (%)
Gender (*n*: 730)	
Males	360 (49.3)
Females	370 (50.7)
Age in years; mean (standard deviation)	42 (12.13)
Highest attained degree (*n*: 728)	
Primary school	177 (24.3)
High school	388 (53.3)
Bachelor	183 (19.0)
Master	25 (3.4)
Type of mental health problems* (*n*: 708)	
Mood and anxiety	300 (42.2)
Substance-related	209 (29.5)
Psychotic	172 (24.3)
Personality	214 (30.2)
Cognitive	93 (13.1)
Other (e.g., ABI…)	50 (7.1)
Time not employed (*n*:693)	
Never worked	52 (7.5)
> 2y.	333 (48.1)
≤ 2 y.	142 (20.5)
Still employed	166 (24.0)
Current hospitalization duration (*n*: 684)	
≤1y	398 (58.2)
>1y	164 (24.0)
Other (DAC, Sheltered Housing)	122 (17.8)
Employment Concerns (*n*: 719)	
Very often - regularly	302 (42.0)
Sometimes	174 (24.2)
Seldom-never	243 (33.8)

*Frequencies and percentages of cases are reported. In total, 38.7% of respondents reported multiple mental health problems

Questionnaire development

The items of the questionnaire were based on items concerning vocational goals, barriers and possible support options published in previous studies (Ali, Schur, & Blanck, 2011; Secker, Grove, & Seebohm, 2001; Secker & Gelling, 2006). In order to make the items valid for the Belgian context, the questionnaire was updated using a process of continuously requesting feedback from two clinician groups and two patient groups. One clinician group comprised four VR counsellors, the other three vocational therapists and one psychologist. Patients of the patient groups were hospitalized at different types of wards. In total, 14 patients were involved in three patient groups. Each item was checked for comprehensibility, clarity and whether it was stigmatizing. Patients requested the

addition of 'work experience program' (unpaid internships with off-the-job counselling by a mental health clinician) as an alternative vocational goal. They also requested to let their key clinical worker indicate which mental health problems are present instead of asking patients for official diagnoses. When asking the patients how many barriers they perceive, patients needed examples of such barriers and three were chosen (i.e., sensitivity for stress, hindering symptoms, and lack of adequate transportation). Lastly**,** questionnaires were sent to and approved by the participating hospitals' ethical boards.

Measures

A first set of multiple-response questions asked patients to indicate their short- and long-term vocational goals, including competitive employment, no activity, Sheltered Employment, voluntary work, education, day activity centre, self-employment, domestic work, other (e.g., pension) and 'work experience program' (Secker et al., 2001). In a next question, patients indicated how many vocational barriers they perceive on a continuum from 'none' over 'some' and 'multiple' to 'many' (Secker et al., 2001). A final question explored which kinds of vocational support were perceived as necessary. This is a multiple response item with increasing level of support options, i.e., 'no support', 'administrative and informative support', 'support with job search and solicitation trainings' and 'on-the-job support'. Clinicians received the same list of vocational options, barriers and supports and they indicated which they consider realistic, present or needed respectively for a particular patient.

Data collection

Each psychiatric ward chose a start date on which questionnaires were offered to all hospitalized patients and the key clinician with whom a particular patient had the most contact. No questionnaires were offered to patients younger than 18 or older than 64 years or to those for whom participation was expected by the clinician to result in worsened well-being. Questionnaires were paired; each questionnaire had a unique code so that clinicians could complete the questionnaire with a specific patient in mind. Some clinicians filled in multiple questionnaires depending on how many patients they were offering support. All participants provided written, informed consent. Patients could request help from a mental health clinician who did not fill in a questionnaire for that particular patient.

Data analyses

Because multiple vocational goals could be selected, data are offered as percentages of cases as was done in Secker, Grove, and Seebohm (2001). These percentages indicate how many respondents select a particular vocational option.

Binary logistic regression analyses with deviation contrasts were used to assess how patients' correlates (age, gender, time not employed, time hospitalized, mental health problems, and highest attained educational degree) are related to competitive employment interest.

Differences between patients' competitive employment goals and clinicians' perspectives were checked using Chi²-tests, kappa with linear weighting and Cramer's V which is an effect size measure for contingency table analyses (Cohen, 1968; Gibbons, Bédard, & Mack, 2005). Kappa and Cramer's V were interpreted as recommended; ≤ 0.20 = poor to slight agreement, 0.21–0.40 = fair, 0.41–0.60 = moderate, 0.61–0.80 = substantial and 0.8–1.0 = almost perfect agreement (Landis & Koch, 1977). To study the trend of disagreement, McNemar-Bowker's test for symmetry (Bowker, 1948) was used as it checks for a significant difference in frequencies below and above the diagonal in the cross table. The item concerning vocational support was a multiple response item. To compare patients' and clinicians' perspectives, the most intense vocational support option of each person was compared.

Results

In the short term, 35.5% of the patients preferred competitive employment and 21.8% preferred voluntary work (Table 2). Both vocational options were also the most favoured options in the long term by 44.6% and 14.6% of patients, respectively.

Table 2. Vocational goals of patients and clinicians

	Patient % of cases (*n*)				**Clinician % of cases (*n*)**			
	Short term		Long term		Short term		Long term	
Competitive employment	35.5	(260)	44.6	(327)	24.1	(167)	32.4	(228)
No activity	16.0	(117)	9.3	(68)	19.6	(136)	6.8	(48)
Sheltered Employment	11.7	(86)	10.4	(76)	14.9	(103)	17.8	(125)
Voluntary work	21.8	(160)	14.6	(107)	26.8	(186)	18.0	(127)
Education	17.5	(128)	10.1	(74)	9.5	(66)	4.7	(33)
Day activity centre	16.0	(117)	10.2	(75)	34.6	(240)	24.6	(173)
Self-employment	4.4	(32)	3.5	(26)	1.0	(7)	1.4	(10)
Domestic work	16.6	(122)	7.5	(55)	33.9	(235)	13.8	(97)
Other (e.g., pension)	2.2	(16)	1.8	(13)	1.7	(12)	0.7	(5)
Work experience (in open job market)	6.1	(45)	4.2	(31)	16.7	(116)	10.5	(74)

Some patient characteristics were associated with competitive employment interest in the long term, $\chi^2(14) = 194.077$, $p < .001$, Nagelkerke R^2: 36.4%, correctly classified cases: 74.1%. Compared to the overall group, those opting for competitive employment in the long term were more likely to (i) be younger (OR: .943, p<.001), (ii) have substance-related problems (OR: 2.519, p<.001), (iii) are less than two years not working (OR: 1.674, p:.007) or (iv) are less than one year hospitalized (OR: 1.422,

p:.013). Patients with only a primary school degree (OR: 0.504, p<.001), who face psychotic problems (OR: 0.513, p:.009), who are not working (OR: 0.453, p:.007) or who have not worked for more than two years (OR: 0.622, p:.005) were less likely to favour competitive employment.

According to clinicians, realistic short-term options were day activity centres (34.6%) and domestic work (33.9%). Competitive employment was realistic according to 24.1% (short term) and 32.4% (long term) of clinicians. Some patient characteristics were associated with clinicians' perspectives, $\chi^2(14) = 278.328$, $p < .001$, Nagelkerke R^2: 51.1%, correctly classified cases: 82.1%.
Compared to the overall group, clinicians were more likely to find competitive employment realistic on the long term for patients (i) who have been not working less than two years (OR: 1.594, p:.020) or (ii) who have substance (OR: 2.732, p<.001) or emotional (OR: 2.158, p:.003) symptoms. It was also considered more realistic when the patient is less than one year hospitalized (OR: 2.868, p<.001). Competitive employment was considered less realistic for patients who have been not working more than two years (OR: 0.346, p<.001), are older (OR: 0.953, p<.001) or who have multiple mental health problems (OR: .596, p:.013). It was also perceived less realistic for patients holding only a primary school degree (OR: .333, p<.001) or hospitalized more than one year (OR: .607, p:.031).

Competitive employment was the option most frequently selected by patients and is also focused on during IPS services. Therefore congruence with clinicians' perspectives was evaluated. There was a moderate relationship between clinicians' perception of competitive employment and patients' competitive employment goals in both the short (χ^2 (1,688):128.05, p<.001, weighted Kappa: .42, CI:.35-.50, Cramer's V: .431, p<.001) and long term (χ^2 (1,704):176.00, p<.001, weighted Kappa: .48, CI:.42-.54, Cramer's V: .50, p<.001). In 18.3% of pairs (*n*: 126), patients opted for competitive employment whereas clinicians did not find this realistic. If the patient was willing to work in the short term, the odds of clinicians indicating competitive employment was 9.03 (OR) times higher than if the patient was not willing to work. The same trend was true in the long term (OR: 11.2) (Table 3).

Concerning their perspective on vocational barriers, patients and clinicians agreed in 33% of the cases (*n*: 227 of 683 patient-clinician dyads). The level of agreement between clinicians' and patients' perspectives on vocational barriers was poor, χ^2 (9, 683): 38.998, p<.001, weighted Kappa:: .13, CI:.08-.17, p<.001, Cramer's V: .138, p<.001.In 49% of cases (*n*: 335) clinicians perceived more barriers than patients (Bowker's test (6, *n*: 683): 150.608, p<.001). Patients who desire competitive

jobs perceived significantly fewer vocational barriers compared to those who did not want such jobs (U: 44497.00, z:-5.054, p<.001).

Table 3. Agreement between patients' goals and clinicians' perception

Patient-Clinician		short term	long term
		% (*n*)	% (*n*)
agreement	yes-yes	17.6 (121)	26.4 (186)
	no-no	57.4 (395)	48.4 (341)
disagreement	yes-no	18.3 (126)	19.2 (135)
	no-yes	6.7 (42)	6.0 (42)
χ^2		128.05***	176.00***
Cramer's V		.431***	.500***

Concerning vocational support, patients and clinicians selected the same support in 32% of the cases (n: 434). There is a significant association but poor agreement between clinicians' and patients' most intense vocational support type, χ^2 (9, 648): 58.000, p<.001, weighted Kappa: 0.11, CI: .07-.15, p<.001, Cramer's V: .173, p<.001). Clinicians selected more intense vocational support options in 38% of the cases (Bowker's test: 33.469, df 6, p<.001). Patients who favoured competitive employment requested more intense vocational support compared to those who did not favour such jobs (U: 51805.5, z:-2.647, p:.008).

Discussion

While some previous articles have shown that clients of community-based services want to work, few studies focused on hospitalized patients with mental disorders. This study shows that many hospitalized patients still prefer competitive employment although many clinicians do not perceive this option as realistic. In addition, clinicians and patients often disagree on the level of barriers to employment and the appropriate ways to overcome them.

Although the interest of 45% of hospitalized patients for competitive employment in the long term seems to replicate some earlier research concerning people with SMI who were receiving community-based care (McQuilken, Zahniser, Novak, Starks, Olmos, & Bond, 2003), this interest is less than found by most of the preceding studies, which reported percentages up to 90% (Rogers, Walsh, Massotta, & Danley, 1991; Van Audenhove & Wilmotte, 2004). The low interest in competitive work might be partially attributable to socio-cultural differences between countries

resulting in more negative attitudes and concerns towards competitive employment in Belgium. Belgian psychiatric hospitals only recently started to focus on VR and clinicians are not educated to initiate a VR process. Besides, there is great reliance on Sheltered Employment and volunteering (Shima et al., 2008) and these are often seen as the principal vocational alternatives to competitive employment (Marwaha, Balachandra, & Johnson, 2009). As confirmed by our data, clinical professionals hold the expectation that competitive employment is not realistic for most of their hospitalized patients. This partly parallels the study by Marwaha et al. (2009), which indicated that, although clinicians may overall believe that people with psychosis are capable of working, they also find many of their patients incapable of competitive work. As a result, clinicians may be less encouraging, explore employment goals less or refer to pre-vocational services instead of services that focus on competitive jobs (Marwaha & Johnson, 2005; Shima et al., 2008). According to the interpersonal expectancy effect, clinicians' expectations and behaviours influence those of patients. Patients might expect vocational failure which negatively affects their hope and intentions to pursue employment (Goscha et al., 2013; O'Connell & Stein, 2011). The attitudes and behaviour of both the patient and the clinician will result in a reduced competitive employment rate, which acts as a self-fulfilling prophecy, for it seems to confirm the clinicians' and patients' perceptions that competitive employment is unrealistic (O'Connell & Stein, 2011; Rinaldi et al., 2008).

Consistent with the finding that patients and clinicians differ on employment goals, the results show that there is little agreement on the extent of barriers to employment and the steps possible to overcome barriers. Clinicians perceive more barriers and indicate that more support will be needed to overcome them. Divergent perceptions of vocational goals, barriers and the interventions needed to find jobs indicate a lack of consensus and vague treatment plans. A lack of consensus is problematic, as it may lead to reduced effectiveness of treatment (Tryon & Winograd, 2011) and a poor therapeutic relationship with the clinician. Such a poor relationship can negatively affect the subsequent relationship with the VR counsellor. Yet, such a good relationship with the VR counsellor is essential for achieving high competitive employment rates (Catty et al., 2011). In contrast, when a patient and a clinician reach a consensus and the patient perceives that the clinician believes in his or her possibilities, better outcomes can be expected (Marwaha & Johnson, 2005; Roth & Crane-Ross, 2002). Hence, it is important for the clinician to create a positive relationship by offering hope, asking timely questions regarding the patients' vocational goals and seeking an initial consensus regarding the treatment plan (Drebing et al., 2004).

Limitations and future research

A limitation of the study is due to the method of recruiting participants. Self-selecting bias may be present as all hospitalized patients were offered a questionnaire but patients decided themselves whether or not they wished to participate. Non-response analyses showed that non-responders were older and had more often psychotic symptoms. We hypothesize that those not responding are also less interested in competitive jobs, so the overall population interest may be even lower than reported.

Further research must focus on how the clinician's age, employment history or educational level affects patients' vocational goals and employment rates. This could be part of a longitudinal study in which the changes in perspectives and the level of agreement during hospitalization are investigated. Subsequent research will also need to focus on interventions to reduce incongruences between clinicians and patients but also between clinicians of different organizations as they can hold very different perspectives (Knaeps, Neyens, Donceel, & Van Audenhove, 2014).

Implications

Many people with mental disorders have undetected needs and goals (Gibbons et al., 2005; Waghorn, Saha, & McGrath, 2014). Policy makers and management have to sensitize and train clinicians concerning their role in VR and the importance of employment in people's lives (Marwaha & Johnson, 2005). Clinicians can be stimulated to discuss vocational concerns early in treatment by offering training on motivational interviewing and shared-decision making concerning the type of job and type of support. In addition, patients need to be made aware that employment is important and that it can be addressed during treatment. Overall, contact between VR counsellors, patients and clinicians need to be stimulated.

Conclusions

To our knowledge, this study was the first to include both clinicians and patients when exploring vocational recovery. Contrary to patients, many clinicians do not consider competitive employment a realistic vocational option. Moreover, the opinions of patients and clinicians differ regarding vocational barriers and what is needed to overcome these barriers. Clinicians need to be aware of their patients' vocational needs and should make work of a positive collaborative engagement. In addition, it is important that Belgium further reduces the number of hospitalizations and increase the number of community-based services.

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Table. Correlates of long term competitive employment goals

	Long term - patient				Long term - clinician			
	OR	Sig.	95% C.I.		OR	Sig.	95% C.I.	
Sex (Male*)	1.048	.840	.664	1.655	.732	.262	.425	1.262
Age (mean)	.943	<.001	.925	.961	.953	<.001	.932	.974
Highest attained degree		<.001				<.001		
Primary school	.504	<.001	.365	.696	.333	<.001	.219	.505
High school	.854	.229	.660	1.105	1.157	.350	.853	1.569
Bachelor/Master (reference)								
Type of mental health problems		.002				<.001		
Mood and anxiety	1.189	.435	.770	1.837	2.158	.003	1.301	3.581
Substance-related	2.519	<.001	1.514	4.191	2.732	<.001	1.559	4.789
Psychotic	.513	.009	.312	.845	.580	.090	.308	1.090
Personality	.711	.210	.417	1.212	.761	.377	.415	1.395
Comorbid	.814	.224	.585	1.134	.596	.013	.396	.897
Other (reference)								
Time not employed		<.001				<.001		
Never worked	.453	.007	.256	.802	.901	.757	.466	1.743
> 2 years	.622	.005	.447	.864	.346	<.001	.229	.524
≤ 2 years	1.674	.007	1.154	2.429	1.594	.020	1.076	2.361
Still employed (reference)								
Time of current hospitalization		.034				<.001		
≤1 year	1.422	.013	1.077	1.878	2.868	<.001	1.992	4.129
>1 year	.789	.147	.574	1.087	.607	.031	.385	.956
Other (reference)								

Note. * Reference: female

Table. Perceived barriers by patients and clinicians (Freq)

Patient	Clinician			
	None	Some	Multiple	Extensive
None	12	35	72	51
Some	7	37	85	33
Different	8	29	115	59
Extensive	5	8	64	63

Table. Patients' and clinicians' selection of vocational support (multiple responses, Freq)

	Clinician			
Patient	None	Information, administrative help	Job search, solicitation training	On-the-job coaching
None	54	91	51	56
Information, administrative help	49	143	113	100
Job search, solicitation training	23	122	148	104
On-the-job coaching	28	94	86	89

Chapter 5

VR programs and IPS

Knaeps, J., DeSmet, A., & Van Audenhove, C. (2012). The IPS fidelity scale as a guideline to implement supported employment. *Journal of Vocational Rehabilitation*, *37*(1), 13-23. doi: 10.3233/JVR-2012-0596

The IPS fidelity scale as a guideline to implement supported employment

Abstract

Objective: Despite the wish of many people with SMI to work in a competitive job, employment rates are low. IPS is more effective than other vocational rehabilitation methods in achieving employment and its use should be extended to bridge the gap between user wish and reality. This study measures possibilities to implement IPS in Flanders, by investigating current use, barriers and facilitators across a wide range of services.

Method: Semi-structured interviews with 17 vocational rehabilitation agencies were conducted, using the IPS Fidelity Scale and a list of open-ended questions on perceived barriers and opportunities. Results were analyzed via thematic analysis.

Results: Results show an overall lack of implementation of IPS in Flanders, especially on the four core elements for which most evidence exists. An external style of attributing barriers to environment factors or client characteristics is apparent which could lead to a sense of resignation among counselors.

Conclusions: The use of the IPS fidelity scale and open-ended questions has provided concrete levers to prepare for implementation: a strong leadership in the agencies to encourage optimism towards regular employment for people with SMI; closer co-operations between employment agencies, care agencies and employers; and a more facilitating legislation concerning using IPS.

Key Words: Individual Placement and Support, IPS Fidelity Scale, Barriers, Implementation

Introduction

Work is an essential part of life. Besides the monetary value, it improves self-esteem, establishes social relationships and offers a goal in life [1]. Most of these benefits do not result from keeping oneself busy, but lie in the societal meaning of having a regular, valued and competitive job [2].

For people with severe mental illness (SMI) competitive jobs, which pay at least minimum wage and are open to any person regardless of disabilities [3], are hard to obtain and keep [4]. Employment rates in the US among people with SMI are as low as 10 to 20% [5] and around 20 to 30% in Europe [6, 7]. And this while the majority of people with SMI wants to work in a competitive job and can achieve this with ongoing support [8]. Similar trends in employment rates and user preferences are observed in Flanders, with its six million inhabitants the largest region in Belgium [9].

Evidence-based approaches to support people with SMI in employment are grouped under the umbrella of Supported Employment (SE) [8, 10], of which the Individual Placement and Support (IPS) model shows the best outcomes [11, 12]. The IPS-model is founded on seven principles: (1) zero exclusion, (2) integration with mental health treatment teams, (3) start from consumers' preferences, (4) rapid job search, (5) competitive employment as goal, (6) time-unlimited follow-up and (7) benefits counseling [13]. The IPS-model is the standardization of SE-principles [3], the terms SE and IPS will therefore be used as synonyms throughout the article.

IPS has shown its value in both US and Europe by helping roughly twice as many people with SMI in finding a regular paid job as traditional vocational services do [8]. The Eqolise trial in six European countries [12, 14, 15] demonstrated that these superior employment outcomes can be achieved in countries with very different employment contexts, health care policies and benefits systems.

Flanders has a highly protective benefit system and resulting benefits traps for users, as well as a fragmentation of the offer across several (pre-)vocational services and different policy levels with inconsistent regulations [16]. Furthermore, employment outcomes of these services are poorly registered. This background does not provide sufficient incentives for people with SMI to return to work [17].

Vocational rehabilitation in Flanders relies strongly on traditional psychiatric rehabilitation, with a large offer of sheltered work for people with SMI. Although for some, sheltered workplaces are helpful in developing work attitudes and increasing resilience to experiences of failure [18], there is a great number of users in sheltered workplaces, ranging from 25% to 70%, who prefer to work in regular paid employment [9,19,20]. In order to bridge this substantial gap between preference and

employment reality, effective methods in supported employment should be further disseminated in Belgium and possibly other countries with a strong reliance on sheltered work [21].

Thanks to a recent mental health care reform in Belgium, policy makers strive towards more community care and user empowerment [22]. This reform is the next phase in deinstitutionalization of the mental health care offer by reducing the number of psychiatric beds and putting a solid outpatient alternative in place [23]. As an increasing number of people with SMI in Belgium will live in the community in the next coming years, regular paid employment will become more important as a way to attain social inclusion. The reorganization of care in Belgium has currently started in 19 regions (www.psy107.be). In these regions, psychiatric hospitals have formed cooperative networks with e.g., primary care, low-threshold social services, supported housing initiatives and employment services to provide a full mental health care offer that can meet the person's needs and allows for maximum community integration. Rather than closing the existing institutions and setting up new facilities that are more community-oriented, policy makers have chosen to reorganize the existing different care forms in collaborative networks and to retrain staff in using evidence-based methods consistent with balanced care. Supported employment is one such method that staff currently working in day activity centers or sheltered workplaces may need to master in the future. In fact, some of the Flemish regional reorganization projects are already investigating the potential of working together with the Flemish Employment Service to add an employment specialist to their newly set up mobile teams. It is evident that a change towards community care should start with supporting competitive employment, as work provides many benefits that are crucial in a person with SMI's recovery process [24].

This study was set up to provide guidelines for SE implementation to employment and health care professionals in Flanders, and in generalization to those in other countries with a high reliance on sheltered or pre-vocational forms of employment support, desiring to change to more community care.

A first objective of the study is to investigate the extent to which vocational rehabilitation services in Flanders currently apply IPS-principles. The second objective is to understand what hinders and facilitates the future use of IPS, which is essential when considering starting to use SE [25, 26].

Methods

Studies on implementing or evaluating IPS often follow a quantitative research method using Fidelity Scales [27-29] whereas other studies use qualitative approaches [30]. This study combines both quantitative and qualitative research methods, similarly to studies by Bond et al. (2008) [31] and

Porteous and Waghorn (2007) [32]. In both studies, qualitative data collected in interviews with occupational therapists or implementation monitors enrich the quantitative data and give insight in the implementation progress as experienced by counselors [31, 32].

Sample

We aimed to interview approximately 20 agencies to keep data collection feasible in the time available, while also striving for a maximum geographical spread in Flanders and representation over different agency types. As the mental health care reform in Belgium may urge current sheltered workplaces or activation programs to adapt and (also) offer Supported Employment when called for by the needs of the service user, we have chosen to include a broad range of agency types, such as sheltered workplaces and pre-vocational training agencies, that are not usually included in IPS implementation studies. Recommendations for future implementation should not only consider those agencies that are already closest aligned with the SE philosophy, but also those who are less familiar with evidence-based methods in supporting people in competitive employment and who might face different challenges in implementation.

The Flemish Employment Service provided a list of contact details for agency types which are under their authority (e.g., SE agencies, pre-vocational training) as well as some contacts for other types of agencies (e.g., vocational rehabilitation offered via mental health care institutions), known to them through networks, conferences or cooperation projects. As this first list was not comprehensive, it was further completed by searching on websites of official umbrella or government organizations, resulting in a list of 231 officially registered agencies providing vocational rehabilitation to people with SMI. A purposive sample of contacts with explicitly mentioned coordinates on the list or official websites was chosen as this was considered a sign of their personal expertise in vocational rehabilitation. This is an appropriate method for qualitative research to guarantee that the subjects will be good informants for the study [33].

The list was organized by agency type and province and the first-occurring agency with contact details was iteratively selected. Twenty-three agencies were thus selected over several agency types and contacted by telephone or e-mail. Seventeen were willing to participate (response rate 74%). Participating services included are: regional job coaching centers, vocational counseling centers, vocational training agencies, day-activity centers, sheltered or social workshops, vocational units in psychiatric hospitals, and pre-vocational counseling agencies (Table 1). Those declining did so because of lack of time or perceived lack of experience on the subject.

Table 1 Categorization of employment services for people with SMI

Category	Goal	Vocational Services	Number of agencies in sample	Number of agencies in Flanders
Supported Employment	Regular paid employment			
		Regional job coaching centers	4	4
		Vocational training agencies	3	12
		Vocational counseling centers	1	6
Sheltered Employment	Focus on latent benefits of work			
		Day-activity centers	1	n.o.d.*
		Sheltered or social workshops	2	164
		Vocational units in psychiatric hospitals	2	n.o.d*
Pre-vocational counseling agencies	Focus on empowerment and counseling			
		Pre-vocational counseling agencies	4	45

* No official data is known

Participants were interviewed between Oct-Dec 2010 in a private work office. Interviews lasted between 60 to 120 minutes and were audio-taped for later scoring. All participants provided written informed consent. On three of the seventeen interviews two persons were present. Of the total of 20 interviewees, there were 11 women and 9 men, aged between 24 and 56 years old (M: 36, SD: 9.13), with on average 7.6 years experience in vocational rehabilitation (SD: 6.19). All interviewees worked with persons with mental illnesses.

The unit of analysis is the participating service, therefore agencies are grouped in three categories. The first is the category of Sheltered Workshops which includes agencies focusing on developing work habits and skills. A second is that of SE-programs. These strive towards assisting individual placement in competitive employment as quickly as possible [18]. A third category is that of pre-vocational training centers. This type of 'activation' program is a pilot project currently being evaluated in Flanders and consists of a combination of mental health care interventions and 'vocational empowerment' sessions [34]. It is similar to sheltered workshops in that it aims to improve skills, but these programs are strictly therapeutic individual encounters for a maximum of 18 months and do not necessarily provide any work experience

Instruments

IPS fidelity Scale

High fidelity to IPS is a prerequisite to successful vocational outcomes [35, 36] and can be assessed by the IPS Fidelity Scale [37], which differentiates between IPS programs and other vocational approaches [37] and has good content and concurrent validity [38]. Content validity was established by practitioners employed on supported employment teams and experts in vocational rehabilitation who endorse that critical ingredients of supported employment are comprehended by the IPS Fidelity Scale [38]. Concurrent validity was proven by a correlation of 0.85 between the Quality of Supported Employment Implementation Scale (QSEIS) and the IPS Fidelity Scale [39]. Internal consistency of the total scale is high (0.92) and interrater reliability is very good with intraclass correlations for individual items ranging from 0.67 to 0.99 [38].

The IPS fidelity Scale is considered a useful tool in guiding the planning process when considering implementing IPS [39]. The Dutch version of the IPS Fidelity Scale was previously used in the Netherlands [40] and is used in this study as well. It consists of 15 items divided in four factors [41] (Table 2). Each item is scored on a scale from 1 to 5 using mainly quantifiable descriptive anchors [37]. Total scores range from 15 to 75 with scores between 66 and 75 indicating high implementation, scores between 56-65 fair implementation and scores below 55 no implementation [37]. To examine mean item scores, we used the criteria formulated by Bond et al. (2008) [31]. A mean item score below three reflects very low fidelity, while a mean item score between three and four indicates low fidelity. A mean score of four or higher reflects high fidelity.

Barriers and opportunities for implementation

To prepare for implementation, barriers and opportunities need to be examined. According to Bond and Drake (2008) predictors of successful vocational rehabilitation can be divided in three categories: 1) barriers on the client level, 2) on the environmental level of legislation and society and 3) on the organizational level. Predictors on the client level are for example work history and cognitive impairments. Environmental factors can be inadequate co-operation between organizations [3]. Intervention-factors are for example high caseload [3, 42]. Perceived barriers and opportunities were assessed via open-ended questions reflecting these three categories. Examples of the open-ended questions used are: “Which barriers do you experience in finding competitive employment for people with psychiatric disabilities?”, “Thinking back of success stories in your organization for people with psychiatric disabilities, what really made the difference for them, that helped them find and keep a regular paid job?” “Which difficulties do you experience in finding regular paid employment for people with SMI that you would say are related to the approach that is used within your organization or from the program that is used?” and “Which hurdles do you come across in legislation or the

society at large that make finding and keeping regular paid employment for people with SMI more difficult?".

Analysis

The IPS Fidelity Scale was analyzed using the Implementation Resource Kit [43]. Scoring was based exclusively on information from the program manager or a vocational rehabilitation counselor, an approach that is also used by Latimer (2006) [28]. Two researchers independently examined a subsample of 9 interviews. Inter-rater reliability for the total scale is .687 (ICC) based on a one-way random-effects analysis of variance model for agreement between the two assessors. Differences in ratings were discussed until full consensus was reached.

The open-ended questions were analyzed using a hybrid approach of thematic analysis [44] combining data-driven inductive approach and an a priori template of codes based on Bond and Drake's categories of barriers (2008) [45,46]. Data was coded with NVivo 8.0 (2008).

Results

Extent of implementation of IPS

Scores for vocational agencies in Flanders ranged between 25 and 62 (Figure 1). Most agencies score under 55, indicating no implementation of IPS. SE-agencies score between 38 and 62 on the IPS Fidelity Scale, with an average of 49 (SD: 8.77). Within this group, two agencies score above the no-implementation level of 55 and are rated as providing IPS on a moderate level. The six agencies in the Sheltered Employment group score between 25 and 49 (M: 38, SD: 8.73). The four agencies offering pre-vocational training reach a score between 28 and 37, with an average of 32.5 (SD: 3.87).

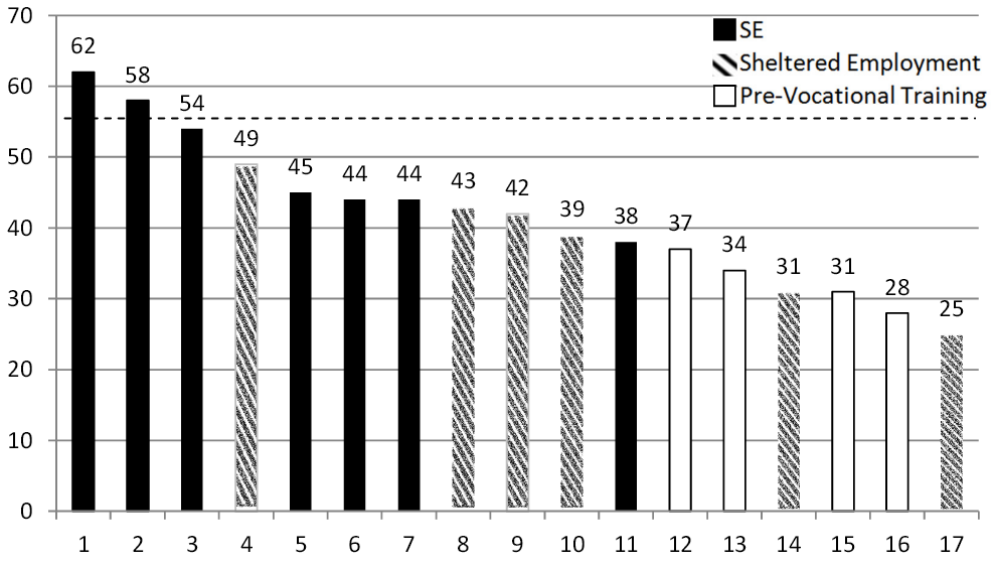

Figure 1. Scores on the IPS Fidelity Scale in categories of services

Of the 15 individual items, only two received overall high fidelity: 'Vocational Services Staff', employment specialists providing only vocational services and 'Vocational Generalists', each employment specialist carries out all phases of vocational service (Table 2). As the two other items composing this factor also score relatively high, 'Vocational Staffing' can be considered the best implemented in Flanders. This indicates that counselors work as a unit, have a manageable caseload and carry out most phases of vocational rehabilitation. However, the relatively high average scores on 'Caseload' are greatly influenced by a small number of outliers, i.e., agencies with a caseload of 25 or less, especially within SE-agencies. One other item that received a reasonably high score was 'Assertive Engagement and Outreach'.

The remaining ten items are rated very low, especially "Integration of rehabilitation teams with mental health". Even in the Pre-Vocational Training agencies that have a combined focus on care and vocational rehabilitation, integration between services is very low. Another component that proved difficult to apply in all organizations was the rapid search for competitive jobs, even in SE-agencies. As the other items within the 'Job Selection' factor also showed a low implementation, the overall score on this dimension was low.

Factors inhibiting and facilitating implementation of evidence-based principles

In total, 168 reports of barriers were coded, divided in 3 categories and 22 different basic themes (Table 3). Opportunities were often mentioned as the absence of barriers, they are therefore discussed together.

Barriers and opportunities at the environmental level were most often mentioned (n: 70, 10 themes). There were no major differences in the number of barriers at the environmental level that were mentioned by counselors of SE agencies (M=4.3), sheltered workplaces (M=4.8) or pre-vocational training agencies (M=4.0). At the client level 64 barriers and facilitators were mentioned (8 themes). Client-related barriers were mentioned least by sheltered workplaces (M=3.6), moderately by SE agencies (M=4.0) and most by pre-vocational training agencies (M=4.5). Least often reported were barriers and opportunities at the organizational level (n: 34, 4 themes). Counselors of SE-agencies report these barriers the least (M=2.0) as do counselors of sheltered Workplaces (M=2.0). Counselors of pre-vocational training agencies mentioned slightly more barriers on this level (M=2.5). Barriers only mentioned once were classified under the theme 'other' (n: 19).

Table 2 Average Scores on IPS Fidelity Scale-items

	Supported Employment (7)		Sheltered Employment (6)		Pre-Vocational Training (4)		Total (17)	
	M	SD	M	SD	M	SD	M	SD
Factor 1: Job selection	**3.46**	**1.48**	**1.73**	**1.23**	**1.30**	**0.92**	**2.16**	**1.59**
Permanence of jobs developed	3.00	1.41	1.83	1.33	1.00	0.00	2.12	1.41
Ongoing work-based vocational assessment	3.00	1.91	2.00	0.89	2.50	1.73	2.53	1.55
Individualized job search	4.00	1.41	1.67	1.63	1.00	0.00	2.47	1.84
Diversity of jobs developed	4.00	1.41	1.50	0.84	1.00	0.00	2.41	1.70
Jobs as transitions	3.29	1.25	1.67	1.63	1.00	0.00	2.18	1.55
Factor 2: Integration with treatment team	**2.39**	**1.26**	**2.83**	**1.40**	**2.44**	**0.89**	**2.55**	**1.24**
Zero-exclusion criteria	1.86	1.25	2.33	1.03	2.00	0.00	2.06	0.66
Assertive engagement and outreach	3.71	0.76	4.67	0.52	3.00	0.00	3.88	0.86
Integration of rehabilitation with mental health treatment	1.00	0.00	2.00	1.10	2.25	1.50	1.65	1.06
Follow-along supports	3.00	1.15	2.33	1.03	2.50	1.00	2.65	1.06
Factor 3: Job development	**3.62**	**1.24**	**2.22**	**1.40**	**2.50**	**1.51**	**2.78**	**1.48**
Vocational services staff	4.86	0.38	3.17	1.33	4.25	0.50	4.12	1.11
Rapid search for competitive jobs	2.86	0.90	1.00	0.00	1.00	0.00	1.76	1.09
Community-based services	3.14	1.21	2.5	1.38	2.25	0.96	2.71	1.21
Factor 4:Vocational staffing	**3.86**	**1.31**	**3.72**	**1.32**	**2.92**	**1.24**	**3.50**	**1.33**
Vocational unit	3.57	0.79	4.00	1.67	3.00	0.00	3.59	1.12
Caseload	3.29	1.89	3.83	0.98	2.00	1.41	3.18	1.59
Vocational generalists	4.71	0.79	3.33	1.37	3.75	1.26	4.00	1.17
Total (M)	3.29	1.44	2.63	1.50	2.29	1.26	2.76	1.51

These results suggest that no differences in perceived barriers exist between the three types of agencies, but the small sample precludes more in-depth statistics analyses per subtheme or on the precise content of the mentioned barriers and facilitators. Therefore no firm conclusions can be drawn on differences in the qualitative data between agency types. Because of the apparent lack of variation between agency types, perceived barriers and facilitators will be discussed for all agency types together in what follows.

Environmental level

Agencies state that employers are reluctant to offer customized internships and jobs. Also, lack of financial stability due to short-time financing of agencies is hindering the implementation of high quality rehabilitation programs. Other factors frequently mentioned are the difficult collaboration between governmental agencies for unemployment services and other services, stigma and benefit traps. Some agencies perceive the numerous legal regulations for unemployed persons with SMI as no longer adapted to the current labor market.

Client level

The most often mentioned facilitator overall is stability of psychiatric problems. Agencies perceive people with schizophrenia and personality disorders as the most difficult to reintegrate in work. Lack of motivation of service users is also said to hinder their employment, together with a poor work-attitude and lack of punctuality or positive working relationships with co-workers. Agencies do not want to burn their bridges with an employer because of a bad experience with an unmotivated client, they prefer to play safe and favor pre-vocational training.

Other barriers are a lack of disease insight and financial problems. Reasons why clients may not be motivated are e.g. co-morbidity and long-time absence on labor market.

Organizational barriers

Organizational barriers and opportunities were least often reported. Agencies find the caseload and administrative workload too high which inhibits a trusting and continuous relationship with clients. High workload of both vocational rehabilitation services and mental health agencies impedes successful collaboration between both organizations. Vocational rehabilitation counselors also experience different values between employment agencies and mental health organizations (6/17). Mental health teams are considered to offer relatively slower recovery processes while vocational rehabilitation counselors say they favor quick integration in work.

Table 3 Perceived barriers by counselors in decreasing rank order of times mentioned

Level	Number of barriers mentioned	Example
Environmental level	70	
Employers	11	"I don't understand why employers are not willing to hire our clients."
Financial support	11	"We receive financial support to offer services, but they are not sufficient for small organizations as ours. The big organizations can rely on their own financial backbone, but we are too small for that".
Collaboration with other agencies (state)	10	"The Public Employment and vocational Training Service needs to communicate more with us: who is the person in charge of a project, who is the person we can go to with questions…"
Crisis and local labor market	8	"…our services depend on the local labor market and what is available on the market."
Stigma and need for awareness campaigns	6	"Employer's willingness to hire them is restricted by fears, lack of knowledge…"
Benefit traps	6	"There are the benefits traps… try to motivate someone to go to work for €1200 when he receives €1100 on benefits!"
Incompatible regulations (law)	5	"The role of internships is not well defined, so people have to do job interviews while in an internship."
Being known in the area	5	"It's a complex organization and all the names of agencies and rehabilitation programs keep changing"
Other	5	"We don't find enough people that can work in the jobs that are available in our agency."
Waiting lists	3	"There is no space anymore in Sheltered Workplaces."
Client level	64	
Psychological problems and stability	15	"Some people experience too much anxiety to come"
Motivation and attitude	12	"People with psychiatric problems often do not want to work at the start of the program."
Socio-economic problems	11	"Some have a lot of unpaid bills."
Social skills	7	"It is important that they can deal with the different personalities of the co-workers on the job…"
Insight	7	"It's difficult to offer services when the person has no idea which direction he wants to proceed in, if he has no insight in his abilities."
Length of absenteeism	4	"A lot of people haven't worked for a long time. And to change that, it isn't easy."
Co-morbidity	3	"People often have behavioral problems in addition to their mental disabilities."

Other	5	"Some are too highly educated for the jobs we offer."
Organizational level	34	
Caseload	12	"I have a caseload of more than 100 clients."
Other	9	"The distance to our centre is for some people too far"
Administrative work	7	"Before someone can start in the rehabilitation process, 25 signatures need to be placed on different documents."
Collaboration with other agencies	6	"Our trajectories do not always parallel those of the psychologist in mental health care."

Discussion

The main objective of this study was to measure the current use and potential for future implementation of IPS in vocational rehabilitation services in Flanders. In order to achieve high competitive employment rates [36, 47] high IPS-fidelity is crucial. Yet, most Flemish agencies are not implementing enough IPS-principles to be considered as offering SE.

There is a strong lack of integration with mental health teams which is a major barrier to IPS implementation [27, 41, 48]. Australia, where responsibilities for mental health care and employment services are also situated at different governmental levels which makes the implementation of IPS more challenging, can provide good examples on how IPS can be implemented via close intersectoral links without reaching full integration [49].

Another shortcoming in current vocational services in Flanders is delaying the search for competitive jobs. A reason for this delay is a fear among counselors to jeopardize their relations with willing employers. There is however strong empirical support that a rapid job search increases employment rates for people with SMI [10].

This means that the SE principles for which outcome evidence is strongest [10], are mostly missing in current Flemish vocational rehabilitation.

On the other hand, vocational staffing elements are reasonably well implemented in Flanders. These are however not considered as crucial in effectiveness by experts and practitioners who have experience in providing SE-services [50].

One specific item of the dimension of vocational staffing warrants attention, namely the caseload. The scores on the fidelity scale for this item were modest for both SE and Sheltered Employment services, but the perception of most counselors in these agencies is that caseload and administrative workload are very high. High caseload can have detrimental effects on the quality of counseling [47,51]. Reduction of caseload will create possibilities for time-unlimited follow-up after the program ends. This is crucial since long term employment is correlated with frequency of contacts during follow-up [52]. Because time-unlimited follow-up is also often constrained by funding arrangements [51,53], funding has to be of a more stable nature. Unstable funding is not uncommon as 22% of SE-agencies in Europe has only short-term funding [54]. However, it is a central factor to achieve high fidelity [36,55] and therefore important when developing strategies for implementing SE [25].

Counselors perceive a need to reform unsuitable legislation hindering the chances of people in getting competitive jobs, which has also been documented in other countries [4]. Especially the

'benefits traps', which lower employment rates of people with SMI because additional disability payments result in a higher income than can be obtained by work [56-58].

Psychiatric symptoms and a lack of motivation of clients are still seen as hurdles for regular work by a majority of the counselors in spite of evidence that people with SMI can and want to work [11]. Counselors continue to attribute barriers to external factors such as client's motivation and inconsistent regulations and to a lesser degree question program factors or their own mind set. This external attribution style can lead to pessimistic perspectives and a feeling of hopelessness with the counselor [12,59]. It has been documented that professionals often do not hold very positive views on prognosis and long-term outcomes [60,61]. This stance will have a negative effect on delivered services [12,59,62] as it is noticed by clients and will ultimately affect their employment outcomes [12,63,64]. Although many studies acknowledge the importance of research on interventions that change counselors' attitudes, few exist [60,65,66]. These few studies emphasize the need to team up with a person with lived experience of SMI to changes counselor's attitudes [67].

Earlier research indicates that zooming in on program factors such as counselors' and supervisors' attitudes can overcome some of the reported client and environmental barriers [3,42]. Strong leadership from a supervisor with positive attitudes towards evidence-based principles and competitive work for people with severe mental illness is a crucial facilitator in this change process [68-70].

And lastly, a great reason for concern in Flanders is the low use of individualized job searches in Sheltered Employment. Individualized jobs searches entails starting from the consumers' job preferences and needs rather than looking at which jobs are available. Without taking the consumers' preferences into account, users in Sheltered Employment who wish to work in a regular competitive environment, will not be heard. This is evident from the low transfer rate of 3% from sheltered workshops to competitive employment [71]. Previous research also observed a low focus on consumer preferences in non-SE-programs [39]. In a country where Sheltered Employment is so abundant, guaranteeing an individualized job search should be of high priority to give everyone who wants to work in a regular paid job the chance to do so.

The study had some limitations. The use of the IPS Fidelity Scale includes analyzing agencies' business reports but as these are lacking or not uniform in Flanders, we restricted ourselves to the information provided in the interviews. This is however also consistent with a potential future use of the fidelity scale by the agencies, which will look for the least labor-intensive approach [39].

Secondly, the sample was drawn from a list of agencies favoring contact persons for whom personal coordinates were available, possibly over-representing those with higher visibility, either via meetings, projects and conferences or via the Internet. This may imply that the sample consists of pioneers in the field of vocational rehabilitation and that therefore the scores on current SE implementation are overestimated. However, we believe this not to be the case, since the list provided by the Employment Service was not purely based on SE-related projects or meetings, and since the low scores on IPS fidelity in the sample do not tend to support this overestimation.
Thirdly, differences in amount of barriers experienced by counselors of different agencies can be very interesting. Preliminary results indicate no differences but due to the small sample, we were not able to determine if agencies with a focus on improving work skills perceive similar barriers as agencies assisting individual placement and support in competitive jobs as quick as possible. This could be a valuable direction for future research.

Conclusions

The application of the IPS fidelity scale together with an open assessment of perceived obstacles to the use of IPS provides concrete levers in the implementation planning process. Organizational factors are neither in the counselor's opinions nor in the IPS fidelity requirements the most important hindering factors. Rather, the crucial elements lie in building co-operations: between health care counselors and vocational rehabilitation counselors; and between counselors and employers. Better co-operations with mental health care and long-term follow-up are needed to avoid the fear of users 'crashing' on the job without a long preparation phase. Cross trainings and regular personal contact are some potential strategies to improve co-operation between mental health care and the vocational rehabilitation worker. [72,73]. Apart from building networks of services, the re-organized mental health care in Belgium will also need to encourage close partnerships between professionals at all levels in the care process.

Better co-operations with employers should reduce the reluctance for a rapid job search. Counselors need to create win-win situations with employers, by presenting positive qualities of the job applicant in productivity and punctuality [74]. An optimistic view among counselors that competitive employment is a viable option for people with SMI and a strong leadership in the agencies to encourage these positive attitudes, are needed to make IPS work. Interventions to promote these attitudes should be organized in close collaboration with people with lived experience of SMI and emphasize the importance of taking the consumer perspective as the starting point. There are finally some macro-level changes that can benefit a future IPS implementation: a more consistent

legislation that overcomes the benefit traps and a more stable funding rather than working with a string of pilot projects.

This study adds to international knowledge on how best to implement evidence-based employment services. Use of the IPS fidelity scale as a management tool gives opportunities to agencies and policy makers to formulate concrete recommendations on how to plan the IPS implementation process. As this study suggests, pre-implementation mapping of agencies' fidelity on IPS and counselors' experiences of barriers, forms a viable strategy for preparing systems change. After implementation, as shown in other studies, measuring the fidelity remains important for agencies in tracking their progress with implementing IPS and in tackling barriers [30].

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Chapter 6

Counselors' focus on competitive employment: Theory of Planned Behavior

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Counsellors' focus on competitive employment: Theory of Planned Behaviour

Abstract

Although the evidence-based Individual Placement and Support programme highlights the importance of the vocational rehabilitation counsellors' focus on competitive employment during career counselling, studies have shown that counsellors do not always target such jobs. This study examines which determinants affect the counsellors' intentions using an extended version of the Theory of Planned Behaviour. Cross-sectional data of 283 VR counsellors of three public employment services were analysed using structural equation modelling. A path model comprising of attitudes, prior behaviour and subjective and moral norms explained 69 per cent of the variance in intentions. The findings indicate that counsellors focus more on competitive employment when they (1) view the placement in a competitive job as positive, (2) experience support, and (3) have prior relevant experiences.

Keywords: Theory of Planned Behaviour, vocational rehabilitation, severe mental illness, counsellors, structural equation modelling

Introduction

Many people with severe mental illness (SMI) want a competitive job (McQuilken et al., 2003; Secker, Grove, & Seebohm, 2001), but have difficulties finding and retaining such a job (Rosenheck et al., 2006). To offer effective career guidance, different vocational rehabilitation (VR) programmes have been developed such as the Individual Placement and Support model (IPS).

IPS stresses the following key principles: (1) VR counselling is open to any person with SMI, such as schizophrenia or schizophrenia-like disorders, a bipolar disorder, severe depression or personality disorders, and who desire paid employment; acceptance is thus not determined by measures of work-readiness nor illness variables (zero-exclusion), (2) integration with mental health teams, (3) potential jobs are chosen based on consumer preference, (4) rapid job search, (5) time-unlimited follow-up, (6) benefits counselling, (7) support to employers, (8) continuous assessment and (9) a focus on competitive jobs (Bond, 1998; Glynn, 2003). The counsellors make sure that employment is taken up in the treatment plan for everyone with an interest in employment (Drake, Becker, Clark, & Mueser, 1999). They provide the full range of VR services to a discrete caseload but do not provide clinical services. By integrating VR counsellors into a clinical team they can easily coordinate services in collaboration with for example psychiatrists (Latimer, 2006). As the VR counsellor can join more than one clinical team, IPS does not depend on specific types of mental health teams (Drake et al., 1999).

The effectiveness of IPS is examined in 14 randomised controlled trials and two Cochrane-reviews. IPS has proven to result in superior competitive employment outcomes compared to traditional VR models focusing on prevocational training (Bond et al., 2007; Crowther, Marshall, Bond, & Huxley, 2001; Kinoshita et al., 2013; Nuechterlein et al., 2008). IPS is regarded as an evidence-based practice (Kinoshita et al., 2013) due to its high effectiveness.

An increasing body of evidence suggests that effectiveness can be reduced when counsellors do not adhere to all IPS-principles (Abraham & Stein, 2009; Goscha, Kondrat, & Manthey, 2013; O'Connell & Stein, 2011). Especially a lack of focus on competitive jobs is shown to decrease employment rates (Marshall, Rapp, Becker, & Bond, 2008). Such a lack of focus might be the result of pessimistic beliefs that paid work is too stressful, will increase symptomatology and is unrealistic (Hugo, 2001; Lauber, Nordt, Braunschweig, & Rössler, 2006; Marwaha, Balachandra, & Johnson, 2009; O'Brien, Price, Burns, & Perkins, 2003). The result of such beliefs is that counsellors have low competitive employment expectations and do not focus on a quick search for competitive jobs (Harris, Matthews, Penrose-Wall, Alam, & Jaworski, 2014; Taskila et al., 2014).
Yet, counsellors' focus can be determined by many other variables such as external barriers, feelings of mastery, social pressures or stigma (Hergenrather, Rhodes, & McDaniel, 2005). Up till now, these variables are not clear and an overall framework of such determinants is lacking. As a result, when trying to improve effectiveness of IPS with training and supervision, it may be that the wrong determinants are targeted.

In order to provide an overall framework explaining differences in VR counsellors' intentions to focus on competitive jobs, this study relies on the Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB). We selected both theories as they successfully predicted employment related behaviours such as job searching and entry into self-employment (Kolvereid & Isaksen, 2006; Ravesloot & Seekins, 1996; Ryn & Vinokur, 1992; Van Hooft, Born, Taris, & van der Flier, 2004). Moreover, Hergenrather, Rhodes, & McDaniel (2005) showed that the TPB explains VR counsellors' intentions to focus on competitive employment for people with AIDS (Hergenrather, Rhodes, & McDaniel, 2005).

Theory of Reasoned Action and Theory of Planned Behaviour

The TRA (Fishbein & Ajzen, 1975) provides a framework of the determinants of behaviours which are under complete volitional control (Ajzen & Fishbein, 1980). The theory asserts that behaviours are determined by the individual's intention (INT) to perform the behaviour. Intentions are in turn a function of two determinants, i.e. a personal factor, called 'attitudes' towards the behaviour and a

person's perception of social pressures, called 'subjective norms'. Attitudes are the individual's overall evaluation of the outcomes of performing the behaviour. Subjective norms refer to whether 'important' others would approve or disapprove of performing the behaviour (Ajzen, 1991; Fishbein & Yzer, 2003; Yzer, 2011).

The TRA was later expanded to the TPB to incorporate behaviours where individuals do not have full control over the situation (Chang, 1998). Therefore, perceived behavioural control (PBC) was added as a third determinant of intentions. The TPB specifies that when people feel they have control over performing a behaviour (e.g., focusing on competitive employment), they will be more likely to perform that behaviour (Conner & Armitage, 1998; Sheeran, Trafimow, & Armitage, 2003). PBC has not always proven to be a strong predictor of intentions. Perceived behavioural control is not always the best reflection of actual control of a person and is often operationalised differently across studies (Armitage & Conner, 2001). In addition, self-efficacy, a person's feeling of mastery (i.e., does one feel capable of performing the behaviour), explains more of the variance in intention than PBC (Armitage & Conner, 2001; Giles, McClenahan, Cairns, & Mallet, 2004; Hyland, McLaughlin, Boduszek, & Prentice, 2012). Therefore we also include self-efficacy. In sum, we expect that attitudes, subjective norms, PBC and self-efficacy of VR counsellors will partially predict their intention to focus on competitive jobs during career guidance (Figure 1).

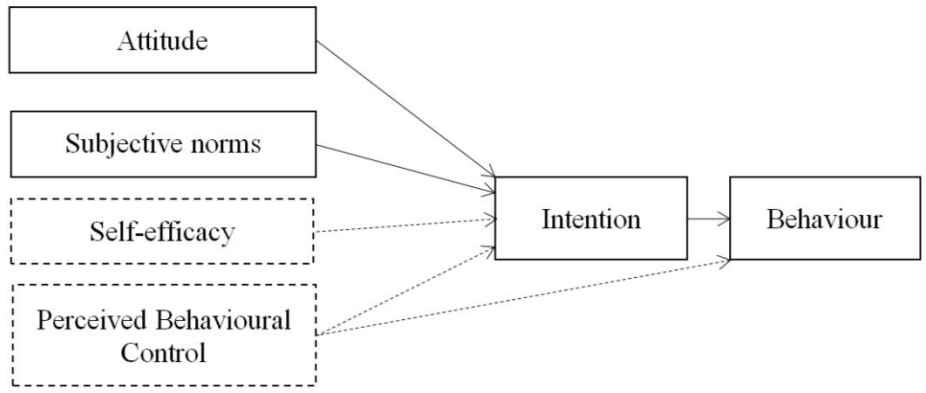

Figure 1.The Theory of Reasoned Action (full lines) and Theory of Planned Behavior (full figure)

Although the four classic TPB determinants are likely to explain a high amount of variance of intentions, variables such as moral norms and prior behaviour have also shown to contribute, in particular circumstances, to the prediction of intentions (Armitage & Conner, 2001).

Moral norms are defined as an 'individual's internalized moral rules' (Parker, Manstead, & Stradling, 1995, p. 129) and take account of 'a personal feeling of…responsibility to perform, or refuse to perform, a certain behaviour' (Ajzen, 1991, p. 199). Their role in the TPB is increasingly studied, yet remains somewhat unclear (Conner & Armitage, 1998; Kaiser & Scheuthle, 2003; Manstead & Parker,

1995; White, Smith, Terry, Greenslade, & McKimmie, 2009). Studies report explained variances of moral norms up to 10per cent. Moral norms are especially important in studies where the behaviour under study is perceived as possibly affecting other people's lives. Such behaviours are for example condom use, organ donation or health professionals' intention to screen for decisional conflict in clinical practice (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Lapinski & Rimal, 2005; Légaré et al., 2007). Some studies relate it to attitudes, while others relate it to subjective norms and even push the subjective norms construct out of the TPB-model (Conner & Armitage, 1998; Harland, Staats, & Wilke, 1999; Kurland, 1995; Légaré et al., 2007; Newton, Newton, Ewing, Burney, & Hay, 2012; Sparks, Shepherd, & Frewer, 1995). In this study, we include moral norms in our model as VR counselling of people with SMI incorporates a moral dimension. Article 23 of the Universal Declaration of Human Rights states that everyone has the right to work. Low competitive employment rates of people with disabilities can therefore be seen as a sign of social exclusion (Crowther, Marshall, Bond, & Huxley, 2001). Moreover, everyone has the right to belong to all levels of society and an inclusive job will often lead to a higher level of contact with a variety of members of society compared to work in segregated work settings. The extent to which counsellors perceive a competitive job as a moral right may thus influence their intentions to focus on such jobs during career guidance. When counsellors are more strongly convinced that competitive employment is a moral right, they may feel more obliged to focus on such jobs during career guidance.

Prior behaviour is a second additional variable considered in this study. Prior behaviour is often omitted in studies as it is seen as already accounted for when measuring the other TPB-determinants. However, research shows that prior behaviour can be an important additional independent determinant (Bamberg, Ajzen, & Schmidt, 2003; Ouellette & Wood, 1998) when the behaviour under study is not well studied, or performed in difficult contexts where a process of deliberative decision making is engaged with (Ouellette & Wood, 1998). The VR context in Flanders is one such difficult and challenging context. VR is organised by a stepped model of three governmental VR agencies, i.e., the Flemish Public Employment Service, the Vocational Training Agency and the local Vocational Counselling Centres. The Flemish Public Employment Service is responsible for the initial contact with the client and the referral to more specialised services and assessment centres. The Vocational Training Agency offers off-the-job services by offering support and setting up an individual action plan including steps to define vocational goals and to overcome barriers. The Vocational Counselling Centres offer even more support in attaining and holding a job, such as job carving (i.e., tailoring jobs to the new employee's characteristics and reassigning responsibilities from current staff to this new person) (Nietupski & Hamre-Nietupski, 2000) and facilitating relationships with employers and colleagues. Although these organisations need to collaborate intensively, many barriers hinder this collaboration. The VR context in Flanders is for example subject to different

political levels (federal and regional) and there exist incompatible legislation and limited collaboration with mental health services (Knaeps, DeSmet, & Van Audenhove, 2012). We therefore hypothesise that, within this specific context, prior behaviour will be a determinant of counsellors' intentions (Figure 1).

Method

Participants

The sample comprised of counsellors from three different employment services. All counsellors from the Vocational Training Agencies (n= 155) and of the Vocational Counselling Centres (n= 154) were invited to participate. In order to keep demands reasonable, a random sample of 155 counsellors from all 1284 gatekeepers of the Flemish Public Employment Service were offered a questionnaire which could be filled in anonymously. In total, 467 VR counsellors received the TPB-questionnaire electronically using an online survey platform.

A complete data set was obtained for 263 VR counsellors (56per cent). The mean age of respondents is 36 years (SD= 8.88, range, 21-59), with a mean length of service of 6.61 years (SD= 5.70, range 0-30). Most respondents are female (n= 217, 82.5per cent) and have daily (30per cent) to weekly (52.5per cent) professional contact with people with SMI.

Measures

A TPB questionnaire was developed according to (1) the international recommendations for measuring TPB-determinants, (2) the results of a study describing the possibilities and barriers experienced by VR counsellors to implement IPS in Belgium (Knaeps, DeSmet, & Van Audenhove, 2012) and (3) a literature review of previous TPB studies. To ensure face and content validity of the instrument, the questionnaire has been revised and adapted by an independent expert in constructing TPB questionnaires. In addition, an expert panel consisting of five VR counsellors working with people with SMI revised the questionnaire. In line with previous studies (Fila & Smith, 2006; Hyland, McLaughlin, Boduszek, & Prentice, 2012; Harakeh, Scholte, Vermulst, de Vries, & Engels, 2004; Lajunen & Räsänen, 2004; Morris, Venkatesh, & Ackerman, 2005; Oreg & Katz-Gerro, 2006), and in order to keep the questionnaire manageable, we aimed for a minimum number of items.

Intention (INT) to focus on competitive employment was assessed with three items (i.e., "I plan/want/will to focus on competitive employment for people with SMI?"). Each item was measured by a 6-point Likert scale (1= completely disagree - 6= agree completely).

Attitude (ATT) was measured by four 6-point bipolar adjective scales. The statement 'A focus on competitive jobs for people with SMI is…' was followed by four descriptions representing underlying

bipolar dimensions of attitudes (harmful for the client-beneficial for the client; unpleasant challenge-pleasant challenge; not useful-useful; unprofessional-professional).

Subjective norms (SN) were assessed by three 6-point Likert scales ('It is expected to focus on competitive employment', 'I have to take competitive employment as a focus' and 'I focus on competitive employment because I feel obliged by my colleagues/supervisor'). Each Likert scale ranged from '1= completely disagree' to '6= agree completely'.

Perceived behavioural control (PBC) focusing on competitive employment was measured by two 6-point Likert scales (1= completely disagree - 6= agree completely): 'It entirely depends on me whether competitive employment is a focus', and 'I decide whether I focus on competitive employment during vocational rehabilitation'.

Self-efficacy was measured by four 6-point Likert scales (1= completely disagree - 6= agree completely) derived from previous research (Ajzen, 2002; Giles et al., 2004; Hergenrather et al., 2005), e.g., 'I believe I am capable of focusing on competitive employment for people with SMI'.

Moral norms were assessed by two items, each on a 6-point Likert scale (1= completely disagree - 6= agree completely), i.e., 'I see it as my duty to focus on competitive employment' and 'I feel morally obligated to focus on competitive employment'.

It is not recommended that Prior Behaviour is measured by using answer categories such as 'often' or 'never' (Ouellette & Wood, 1998). The single item used in this study is therefore: 'In how many cases, up to now, did you focus on competitive employment?' (less than 10per cent, between 10 and 25per cent, between 25 and 50per cent, between 50 and 75per cent, more than 75per cent).

Data analyses

A two-step approach using structural equation modelling (SEM) was adopted (Byrne, 2010; Mueller & Hancock, 2008). First, reliability and validity of the measurement model was checked using a confirmatory factor analysis (CFA). Next, a structural equation model was tested. All analyses were performed using SPSS 22.0 and AMOS 18 (SPSS Inc, Chicago, IL. USA).

The CFA tests the adequacy of the measurements in representing their associated hypothesised constructs using latent (unobserved) variables indicated by the questionnaire items pertaining to each construct. To perform a CFA, all of the constructs with more than one indicator are depicted and composed as one full measurement model. First, the overall fit of the CFA-model was assessed using the Chi^2/df, Root Mean Square of Approximation (RMSEA) and Comparative Fit Index (CFI) goodness-of-fit statistics. Secondly, composite reliability coefficients were evaluated. Composite reliability takes into account the actual factor loadings rather than assuming that each item is equally weighted in the composite load determination as the Cronbach's alpha coefficient does. However, interpretation and threshold (0.70) are similar to Cronbach's alpha (Nunnally & Bernstein, 1994).

Thirdly, convergent validity was assessed using the average variance extracted (AVE). AVE measures the amount of variance that is captured by the construct, in relation to the amount of variance due to measurement error (Zanella & Cantaluppi, 2013) and should be larger than 0.5 (Fornell & Larcker, 1981). In addition to AVE, the standardised loading estimates should be significant. In a last step, discriminant validity was assessed. Discriminant validity is the degree to which measurements of conceptually distinct constructs differ. It was assessed by comparing the AVE for a given construct with the squared correlations between that construct and the other constructs. When AVE is higher, there is evidence for the construct being more strongly correlated with its indicators than with the other constructs in the model.

In the second step, a SEM-testing procedure using bootstrapping due to non-normally distributed data (Byrne, 2010; Field, 2009; Klem, 1995; Won Ho & Eun Young, 2011) was followed. After an initial analysis with all items, model modifications were conducted using an iterative process that involved removing a single path and re-estimating the model (Chang, 1998; O'Boyle, Henly, & Larson, 2001; Pachankis, Rendina, Ventuneac, Grov, & Parsons, 2014; Schreiber, Nora, Stage, Barlow, & King, 2006). Modification indices, standardised regression coefficients and mediation analyses were used to estimate, evaluate and improve the initial model (O'Boyle et al., 2001). The following indices were used: Chi^2/df, RMSEA, CFI and TLI. Benchmarks for these indices are: $Chi^2/df < 5.00$, RMSEA ≤ .08, CFI ≥ .90 and TLI ≥ .90 (Hu & Bentler, 1999; Mueller & Hancock, 2008; Wu, Wang, & Lin, 2007).

Results

Test of the measurement model

The first step in scale validation was to examine the goodness-of-fit of the overall CFA model. Although the CFA resulted in a good fit ($Chi^2(104)=191,119$, $Chi^2/df= 1.838$, RMSEA= .057, TLI= .945 and CFI= .958), there was a lack of discriminant validity between moral and subjective norms. Because literature suggests that moral and subjective norms are theoretically different constructs albeit often correlated, a second-order determinant called 'overall norms' was created (Byrne, 2010). Tests of the new model showed a good overall fit with the data ($Chi^2(107)=205.760$, $Chi^2/df= 1.923$, RMSEA= .059, TLI= .939 and CFI= .952). Standardised loadings were above the minimum threshold of 0.5 and were all significant. Next, construct reliabilities of the adapted model were assessed (Table 1). There is proof for internal consistency of the measurement model since construct reliabilities were all higher than the threshold of 0.7 (range= 0.71 and 0.90). There is also evidence for adequate convergent validity as AVE is higher than 0.5 for all determinants except for self-efficacy (range= 0.48 to 0.80). Yet, the AVE of self-efficacy does not cause a problem as the composite reliability is sufficient. Finally, the AVE for each construct exceeds the squared correlation between that particular construct and each other construct. Thus, the test of discriminate validity was met.

Table 1. Convergent (AVE) and discriminant validity

Determinant	AVE	Intentions	Self-Efficacy	PBC	Norm	Attitude
Intentions	0.75	0.90	0.30	0.01	0.57	0.36
Self-Efficacy	0.48		0.73	0.01	0.36	0.24
PBC	0.56			0.71	0.02	0.00
Norms	0.83				0.90	0.17
Attitude	0.69					0.87

Note. χ^2: 205.760, p<.001, χ^2/df: 1.923, CFI: .952, RMSEA: .059
AVE > .50 indicates convergent validity
Construct reliabilities on the diagonal
Squared correlations between determinants above the diagonal. When AVE of a construct is higher than the squared correlations, there is evidence for discriminant validity

Test of the path model

An iterative process of deleting non-significant paths and re-estimating the model was followed. Model 1 represents the adapted TPB-model (i.e., attitudes, overall norms composed of subjective and moral norms, PBC, self-efficacy and prior behaviour). Fit of this model with the data was good (Table 2). Yet, analysis showed that the standardised regression weight of the Intention-PBC relation was not significant (Standardised Regression Weight= .01, p= .78) and therefore PBC was removed (Table 2). After testing the new model (model 2), satisfactory goodness-of-fit indices were again attained but the Intention-Self-Efficacy relation proved non-significant (Standardised Regression Weight= -.03, p= .74). Deleting Self-Efficacy resulted in model 3, which is a TRA-model (i.e., attitudes and overall norms) with prior behaviour. The standardised regression weight of the intention-Prior Behaviour relationship is small (.13), but significant (p= .015). This is similar to previous findings (Lugoe & Rise, 1999). Due to this small regression weight, the fit of the model slightly decreased, but was still satisfactory. This model accounts for 69 per cent of the variability in intention to focus on competitive employment and is depicted in Figure 2. Although this model was satisfactory, we made one additional modification to test the TRA (model 4), i.e., the removal of the intention-Prior Behaviour relationship. The model proved to be a very good fit of the data with all coefficients significant at the .01 level. This model accounts for 67 per cent of the variability in intention to focus on competitive employment.

Table 2. Model comparison

Indices	Model 1	Model 2	Model 3	Model 4
χ^2 (df)	258.62 (136)	196.57 (108)	122.43 (58)	90.73 (49)
χ^2/df	1.90	1.82	2.11	1.85
AIC	366.62	286.57	188.42	148.73
BIC	555.52	447.31	306.306	252.33
CFI	.95	.96	.96	.98
TLI	.93	.95	.95	.97
RMSEA (CI)	.06 (.05-.07)	.06 (.04-.07)	.07 (.05-.08)	.06 (.04-.08)

Note: CI: confidence Interval

Model 1: INT, ATT, Overall norms, PBC, Self-Efficacy, Prior Behaviour

Model 2: INT, ATT, Overall norms, Self-Efficacy, Prior Behaviour

Model 3: INT, ATT, Overall norms, Prior Behaviour

Model 4: INT, ATT, Overall norms (TRA)

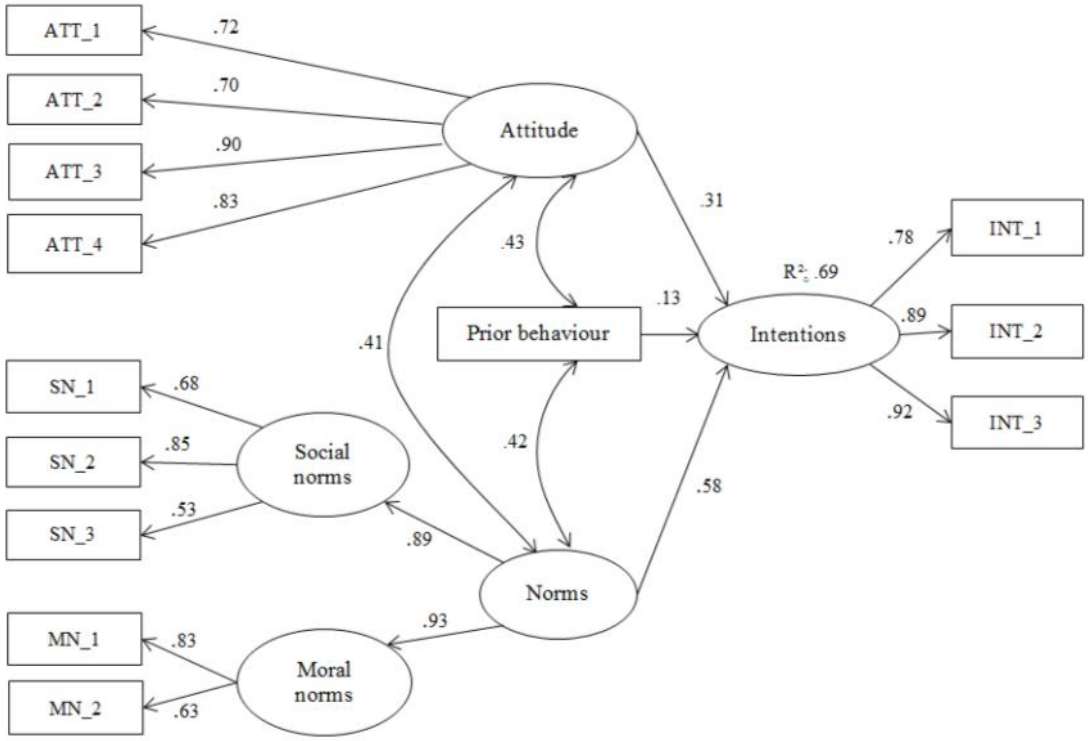

Figure 2.The full path model

Discussion

VR counsellors hold a crucial role in the fidelity and effectiveness of VR programmes. Their intentions to focus on competitive employment for people with SMI are examined using TPB-variables, moral norms and prior behaviour. Three determinants explain differences in the intention of VR counsellors to focus on competitive jobs for people with SMI, i.e., overall norms (subjective and moral norms), attitudes and prior behaviour.

The results provide evidence for Fishbein and Ajzen's (1975) TRA by indicating that norms influence intentions. The importance of subjective norms in VR counselling was already emphasised in a study of the VR counselling of people with HIV (Hergenrather et al., 2005). In addition, our study shows that 'norms' encompass both subjective and moral norms. Subjective and moral norms are two distinct but closely related constructs of overall norms. They are both important predictors of intentions when the behaviour under study is perceived as possibly affecting other people's lives (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Lapinski & Rimal, 2005; Légaré et al., 2007; Quine & Rubin, 1997; Randall & Gibson, 1991; Trafimow & Fishbein, 1994). This is the case during career guidance and VR counselling (Southern & Miller, 2012). We conclude that both VR counsellors' perceptions of what others expect them to do and their moral norms about competitive employment influence their intentions.

In line with previous studies on employment (Hergenrather et al., 2005; Ravesloot & Seekins, 1996), this study shows that attitudes influence the intentions of VR counsellors. When counsellors perceive a focus on competitive employment as potentially harmful, too stressful or unprofessional, they are less likely to focus on this kind of employment.

Prior behaviour significantly contributed to the explanation of intentions beyond the components of the TPB. It contributed to a model with an average fit of the data and this finding parallels other TPB-research (Lugoe & Rise, 1999). We have therefore included it in the model. The results also show that prior behaviour is found to be an independent predictor of intentions. Previous studies reported mixed results concerning the role of prior behaviour in the TPB. Some researchers postulated prior behaviour might be an independent predictor in contexts where the behaviour is not yet (fully) known or when behaviour needs to be performed in complex situations where a process of deliberative decision making is performed (Bamberg et al., 2003; Ouellette & Wood, 1998). Such complex situations are prevalent in the VR context in Flanders and might explain why prior behaviour is found as an independent predictor in this study. The VR situation in Flanders is complex since complicated referral structures are in place and many grants exist. Counsellors and clients need to make a choice which grant suits best and need to support their choice in the applications that always need to be submitted.

Counsellors thus act after taking into account all the possible actions that can be taken, the organisations that have to be informed, or the files that need to be completed.

The findings do not support the extensions of the TRA represented by the TPB. PBC and self-efficacy did not add significantly to the variance explained in intentions. In many TPB-studies, PBC is indeed replaced by self-efficacy measures since these are often better indicators of intentions. This means that the perception that one can achieve the skills to overcome impediments to perform the behaviour is often more influential than the perception of the extent and burden of these impediments. Surprisingly, there was also no effect of self-efficacy on intentions in this study. This means that there is no relationship between the counsellors' feelings of how competent one is to overcome barriers and their intentions to focus on competitive employment. There are other studies that also find weak or non-significant relationships between self-efficacy and intentions or behaviours such as job-search behaviour (Kolvereid & Isaksen, 2006; Ryn & Vinokur, 1992; Van Hooft et al., 2004; Wanberg, Watt, & Rumsey, 1996). Van Hooft, Born, Taris, and van der Flier (2004) offer two explanations for the non-significant relationship between self-efficacy and intentions. Both explanations are associated with the composition of the sample. First, if a subgroup of respondents does not (intend to) engage in the behaviour but has high levels of self-efficacy, this might deflate the relationship between self-efficacy and intentions. Deleting data of VR counsellors with no focus on competitive employment may thus result in more genuine and significant relationships between intentions and self-efficacy. Second, the relationship between self-efficacy and intentions might be different for experienced and inexperienced respondents. People with less relevant years in service, may have less strong relationships between self-efficacy and intentions. In our study, additional analyses show that the relationship between self-efficacy and intentions remained non-significant for a subsample of high intenders and for a subsample of counsellors with less relevant years in service. Hence, the hypotheses of Van Hooft et al. (2004) concerning the association between self-efficacy and intentions cannot be confirmed. Yet, creating subsamples within the data resulted in sample sizes of less than 200 cases, which is too less to attain reliable outcomes with SEM-analyses (Kline, 2011; Lei & Wu, 2007).

Limitations and future research

The findings reported in this study are subject to some limitations. Firstly, self-reports may not always translate directly into actual behaviour (Armitage & Conner, 2001). Future research might explore to what extent the model explains actual behaviour. Secondly, the non-significant relationship between self-efficacy and intentions might be a result of the operationalisation of the self-efficacy construct (Kolvereid & Isaksen, 2006) as the internal consistency of the self-efficacy construct in this study proved to be only moderate. Moreover, the self-efficacy measure is a general

indicator of self-efficacy. A measure of specific self-efficacy beliefs for each barrier that may hinder the performance of the behaviour is likely to produce better results (Bandura, 1997). Yet, adding more items will increase the total number of unknown parameters in the model. The more unknown parameters in the model, the more data SEM requires to acquire reliable outcomes (Byrne, 2010) which may not always be feasible to achieve. Further studies on how to measure self-efficacy may provide a more conclusive answer on the role of self-efficacy in VR counselling intentions. Lastly, our study does not provide evidence for causal relationships as it is cross-sectional. We recommend future research to study the effects on employment outcomes of interventions based on the described model.

Implications

The findings indicate that counsellors are more likely to focus on competitive jobs when they perceive competitive jobs as positive and realistic and when they have prior experiences with finding competitive jobs. But first and foremost, it seems that counsellors may adapt their behaviour when they experience support from supervisors or colleagues; experience a moral obligation to help; and perceive that clients expect competitive jobs. Targeting these variables may increase the counsellors' focus on competitive employment for people with SMI during career guidance and counselling.

To modify the beliefs of VR counsellors, training interventions need to include persuasive communication concerning individual moral norms and perceived consequences of employment. After all, targeting the beliefs regarding the consequences of the behaviour has been identified as a pathway to change attitudes (Fishbein & Ajzen, 1975). In addition, training might provide examples of counsellors who have successfully placed clients living with SMI into jobs; personal experiences (e.g., ensuring that all VR counsellors have worked with a client with SMI); and positive reinforcement (Bandura, 1988). Currently, there is no code of ethical practice for Flemish VR practitioners. The introduction of such a code would provide a framework to guide training programmes and supervisory discussions.

Finally, this and other studies stress the importance of the VR supervisor as an important referent (Gowdy, Carlson, & Rapp, 2004; Marshall et al., 2008). They show that VR counsellors are less likely to place a person with SMI into a competitive job when they experience only limited support by a supervisor. Therefore, supervisors are recommended to acknowledge their influence and their role in disseminating crucial information to assist counsellors in successfully placing clients into competitive jobs; to express their support for VR counsellors' placing people with SMI into jobs; to assist their team members in assessing competitive jobs for people with SMI; and to adopt a goal-focused approach, expecting staff to do the same (Gowdy et al., 2004; Marshall et al., 2008). For this, supervisors need to be trained in effective team management and communication skills.

Conclusion

The TRA provides a systematic framework to study differences in VR counsellors' intentions to focus on competitive jobs. The study shows that in complex VR situations, prior experience with offering VR services to people with SMI is also an important determinant for intentions. It is important that supervisors take up a supportive role for team members in order to facilitate their positive attitude on competitive employment for people with SMI.

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Chapter 7

Beliefs of Vocational Rehabilitation Counselors

Knaeps, J., Neyens, I., Donceel, P., Van Weeghel, J., & Van Audenhove, C. (2014). Beliefs of Vocational Rehabilitation Counselors About Competitive Employment for People With Severe Mental Illness in Belgium. *Rehabilitation Counseling Bulletin*, 1-13. doi: 0034355214531075

Beliefs of Vocational Rehabilitation Counselors about Competitive Employment for People with Severe Mental Illness in Belgium.

Abstract

Vocational Rehabilitation (VR) counselors do not always focus on competitive employment for people with severe mental illness (SMI). Based on the Theory of Planned Behavior (TPB), this study examines how three types of VR counselors (i.e., gatekeepers, case managers and specialists) vary in their underlying beliefs about competitive employment.

VR counselors (n= 286) from Belgium completed an online TPB-survey measuring behavioral, normative, control and self-efficacy beliefs. Differences in beliefs were analyzed by one-way ANOVA's and post-hoc comparisons using Bonferroni correction.

Results indicate that counselors differ in their beliefs regarding competitive employment for people with SMI. Specialized counselors are stronger convinced that competitive employment results in latent benefits (e.g., increased integration and self-confidence). In contrast, gatekeepers consider income as the most recurrent and positive effect. The more specialized VR counselors are, the more often they perceive significant others valuing competitive employment and the more often they may comply with these norms. Finally, specialized counselors experience fewer barriers, more control and more self-efficacy in dealing with problems compared to less specialized counselors.

The differences in beliefs determining the focus on competitive employment may result in a lack of an integrated approach. Training, outcome feedback and intersectoral communication can enhance consistency between different VR services.

Introduction

Approximately nine percent of the six million adults in Flanders (Belgium, Europe) suffered from a mental health problem in the last year and one out of four people will suffer from (severe) mental health problems in their life (Alonso et al., 2004). People with severe mental illness (SMI) have difficulties with obtaining and retaining a competitive job (Organization for Economic Co-operation and Development [OECD], 2013; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Employment rates of people with mental disorders are similar for the US as for Europe and range between 10% and 30% (Arbesman & Logsdon, 2011; Bacon & Grove, 2010; Bond et al., 2007; McDaid, Knapp, & Medieros, 2008; Thornicroft et al., 2004; van Busschbach, van Vugt, & Stant, 2012). Nevertheless, the majority of people with SMI want to work (McQuilken et al., 2003; Secker, Grove, & Seebohm, 2001).

Besides, employment has a positive effect on peoples' social, emotional and financial life (Rosso, Dekas, & Wrzesniewski, 2010).

To help people with SMI obtain and hold competitive jobs, several vocational rehabilitation programs (e.g., Supported Employment, Transitional Employment) have been developed. The Individual Placement and Support model (IPS) of Supported Employment (SE) is the best-researched model and is generally acknowledged as an evidence based practice (Crowther, Marshall, Bond, & Huxley, 2001; Kinoshita et al., 2013). IPS stresses seven principles: (1) zero exclusion, (2) integration with mental health treatment teams, (3) focus on clients' preferences, (4) rapid job search, (5) competitive employment as a goal, (6) time-unlimited follow-up and (7) benefits counseling. A recently added principle states the importance of building relationships with employers (Becker & Drake, 1994; Bond, Drake, & Becker, 2008; Burns & Catty, 2008; Crowther et al., 2001; Kinoshita et al., 2013).

Countries differ from each other in the way VR counseling is organized. In general, at least two of the three following types of VR counselors can be distinguished, i.e., (1) gatekeepers, (2) case managers and (3) VR specialists (Becker et al., 1998; Fleming et al., 2013; Premuda-Conti & Lewis, 2011). Firstly, gatekeepers, working in for example state-federal VR agencies in the US (Premuda-Conti & Lewis, 2011) and Europe (e.g., Public Employment Service in Finland or Jobcentres in the UK), are responsible for the intake, global assessment of competences and referral to more specialized services. If gatekeepers do not believe in the value of competitive employment and perceive too many barriers for obtaining and retaining such jobs, it can be expected that referral to specialized services will be low (Casper & Carloni, 2007). Moreover, as they are the first contact person of the clients with SMI, their focus on competitive employment might influence the first intentions of the person with SMI to search for and retain a competitive job. Secondly, VR case managers assess competences of clients, plan and monitor their VR process and look for jobs (Rapp & Gosha, 2004). They connect the person with VR specialists or other services (Gowdy, Carlson, & Rapp, 2004; OECD, 2013; Rosenthal et al., 2012). VR case managers thus have a mixed profile of generalist and specialist functions (Harries & Gilhooly, 2003). It can be expected that if case managers' intentions are not focused on competitive employment, referral to IPS services will be low (Casper & Carloni, 2007). Moreover, as they have a moderately intensive contact with clients, counselors' intentions may negatively impact clients' intentions to search for competitive jobs. Lastly, specialized or field VR counselors (Premuda-Conti & Lewis, 2011) offer on-the-job support for clients (with SMI) and employers and are responsible for follow-up (Abraham & Stein, 2009). They often work in Community Mental Health Centers, in psychosocial rehabilitation agencies, or in psychiatric hospitals (Corbière et al., 2010; Rinaldi & Perkins, 2007). As their contact with clients is intensive, their focus

on competitive employment is crucial and can strongly impact the intentions of clients to engage in competitive employment.

This study was conducted in Flanders, the largest semi-autonomous region of Belgium. The VR system of Flanders consists of three different organizations, i.e., the Flemish Public Employment Service, the Vocational Training Agency and the local Vocational Counseling Centers. In total, 1596 VR counselors are employed in Flanders. Some important differences between the organizations exist, i.e., the counselors' tasks and caseloads. Gatekeepers of the Flemish Public Employment Service are responsible for the initial contact with the client and the referral to more specialized services and assessment centers. These counselors have a caseload of up to 100 clients. Case managers of the Vocational Training Agency offer off-the-job support to approximately 15000 people with all kinds of employment barriers by setting up an individual action plan. Caseloads are restricted to a maximum of approximately 60 clients. VR specialists of the local Vocational Counseling Centers offer even more support in attaining and holding a job, such as job carving and facilitating relationships with employers and colleagues. Their services are not limited to the hours clients are on the job site, e.g., to call clients after work to ask for feedback. VR specialists have a lower caseload (approximately 30 clients) in order to establish a strong working alliance with their clients.
Besides these differences, some similarities among the organizations exist. Firstly, all Flemish VR counselors offer support to all people with disabilities, i.e., mental, physical or other types of disabilities. Next, Flemish VR organizations receive an a priori budget for each client they serve but do not receive any rewards when a client obtains competitive employment. Thirdly, as no formal training to become a VR counselor exists, organizations offer their own internal trainings. This also means that no degree is required when entering an organization, albeit that in reality a Bachelor's degree is most common. Lastly, salary of the counselors is highly comparable.

As the three types of counselors perform different tasks and are employed in different organizations, they may differ in their attitudes, expectations and focus on competitive employment. When clients meet counselors with different attitudes and intentions, they might experience ambiguity and instable and less integrated support (Henry, 2004) which in turn might affect the working alliance with the VR counselor. Even more, poor communication between the practitioners, i.e., the gatekeeper, the case manager and the VR specialist might lead to poorer attendance of clients at meetings with the VR counselor (Mitchell & Selmes, 2007). Therefore, we conclude that the attitudes, intentions and behavior of counselors of different organizations need to be aligned.

This study explores whether and how counselors' beliefs about focusing on competitive employment are aligned. The specific research questions tested are that counselors of different organizations (1) have different opinions about the outcomes of a focus on competitive employment, (2) have different perceptions of the social pressure to focus on competitive employment and (3) perceive other barriers and have different levels of self-efficacy. A more thorough understanding of the underlying determinants of VR counselors' intentions might improve training by tailoring it to the specific needs of the counselor. Furthermore, aligning the intentions of different types of VR counselors can encourage integration of the VR counseling process.

The Theory of Planned Behavior

The Theory of Planned Behavior (TPB) has been applied within different research domains (Armitage & Conner, 2001; Fila & Smith, 2006; Harakeh, Scholte, Vermulst, de Vries, & Engels, 2004) including vocational rehabilitation (Brouwer et al., 2009; Corbière et al., 2011; Hergenrather, Rhodes, & McDaniel, 2005). Within the TPB, intentions to perform a behavior (i.e., to focus on competitive jobs) are determined by the attitude, subjective norms and perceived behavioral control (PBC) towards that behavior (Ajzen, 1991). These are in turn determined by behavioral, normative and control beliefs (Figure 1).

Attitudes towards a behavior reflect the individual's global favorable or unfavorable evaluation of performing the behavior (Ajzen, 2002a). It consists of two components: behavioral belief strength and outcome evaluation. Behavioral belief strength is defined as the perceived probability that an outcome occurs, whereas outcome evaluation refers to how positive or negative each outcome is perceived (Ajzen, 2002a).

Subjective norms are a person's perception of the social pressure to (not) perform the behavior (Ajzen, 2002a). Subjective norms are determined by normative belief strength and motivation to comply. Normative belief strength refers to the beliefs about how groups of significant others (e.g., partners, supervisors, colleagues, friends) would like one to behave. 'Motivation to comply' indicates whether one is motivated to comply with the desires and expectations of significant others.

The TPB incorporates perceptions of control over the performance of the behavior (Conner & Armitage, 1998). Perceived behavioral control refers to the person's perception of the extent to which performing a behavior is under control (Sheeran, Trafimow, & Armitage, 2003). The underlying control beliefs are characterized by (1) the likelihood that barriers occur, i.e., 'control belief strength' and (2) the extent to which a barrier hinders performing the behavior, i.e., 'control belief power' (Shook & Bratianu, 2010; Terry & O'Leary, 1995).

Self-efficacy can be defined as a personal judgment of one's capabilities to organize and perform behaviors to attain goals and overcome barriers (Bandura, 1977; Shook & Bratianu, 2010). Beliefs about one's own level of self-efficacy are included in this study, as research demonstrates that self-efficacy is a strong predictor of intentions above the other TPB-components (Ajzen, 2002b; Miller & Miller, 2011; Montano & Kasprzyk, 2008; Povey, Conner, Sparks, James, & Shepherd, 2000).

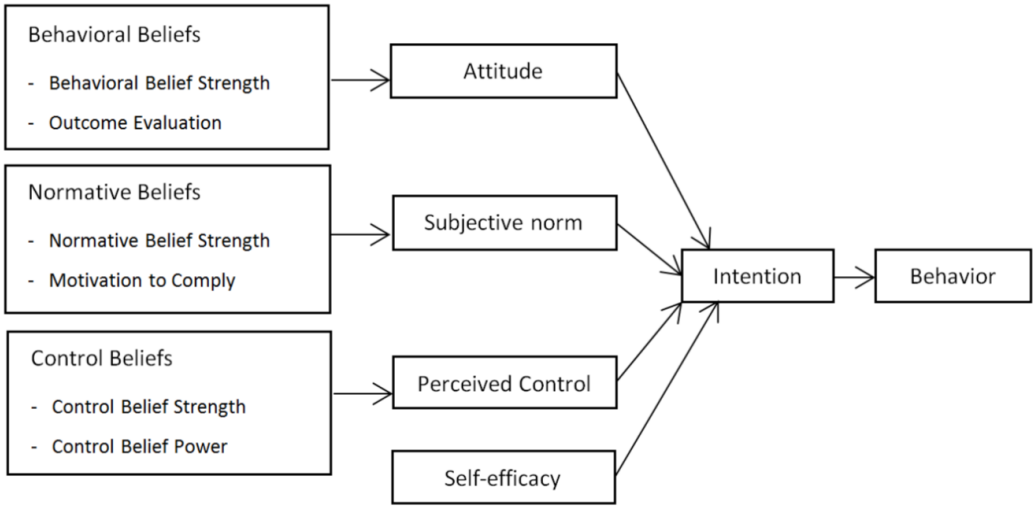

Figure 1. The Theory of Planned Behavior and its underlying beliefs

Method

Sample description

To study the beliefs of the three different groups of VR counselors in their intentions to focus on competitive employment, cross-sectional data was gathered. Of the 467 Flemish VR counselors participating in the study, 286 counselors completed the questionnaire (response rate= 55%). The sample comprised of gatekeepers of the Flemish Public Employment Service, case managers of the Vocational Training Agencies and VR specialists of the Vocational Counseling Centers, all of them working with people with SMI. The mean age of respondents is 36 years (range 21-59, *SD*= 9.0), and the mean length of service was 7 years (range 0-30, *SD*= 5.8) (Table 1). Most respondents are female (*n*= 237, 82.9%) and were having daily to weekly professional contact with clients suffering from SMI.

Gatekeepers of the Flemish Public Employment Service control the access to more specialized services. In order to keep demands reasonable, a random sample of 155 counselors of all 1284 gatekeepers of the Flemish Public Employment Service was selected. There were 69 gatekeepers who completed the questionnaire (response rate= 45%). The mean age of gatekeepers was 41 years (*SD*= 9.2) with on average 8.9 years in service (*SD*= 7.3).

VR case managers of Vocational Training Agencies offer off-the-job support and facilitate the search for jobs. All 158 case managers of the specialized Vocational Training Agencies in Flanders received a questionnaire. It was filled in by 110 case managers (response rate= 70%). The mean age was 32.1 years (*SD*= 6.9) and the average length of service was 4.9 years (*SD*= 3.9).

VR specialists of Vocational Counseling Centers offer on-the-job support. All 154 VR specialists received a questionnaire. Approximately 69% of VR specialists (n= 107) completed the questionnaire. VR specialists were on average 37.0 years old (*SD*= 9.0) with on average 7.1 years in service (*SD*= 5.9).

Significant differences between gatekeepers, case managers and VR specialists emerge on age ($F(2, 283)= 26.39$, $p<.01$) and length of service ($F(2, 283)= 10.79$, $p<.01$). Case managers are significantly younger than VR specialists who are in turn significantly younger than gatekeepers. Gatekeepers and VR specialists report higher job tenure compared to case managers. Significant differences between gatekeepers, case managers and VR specialists also emerged on the amount of professional contact with the target group ($F(2, 283)= 25.56$, $p<.01$) with gatekeepers claiming to have mostly weekly/monthly contact and the remaining two groups stating to have daily/weekly contact. The three groups do not differ significantly on personal contact with clients with SMI ($F(2, 283)= 1.49$, $p= .227$).

Table 1. Summary of respondents' characteristics

Characteristic	All (n= 286)	Gatekeepers (n= 69)	Case managers (n= 110)	VR specialists (n= 107)
Age in years (SD)	36.1 (9.0)	41.2 (9.2)	32.1 (6.9)	37.0 (9.0)
Length of service in years (SD)	6.7 (5.8)	8.9 (7.3)	4.9 (3.9)	7.1 (5.9)
Gender (% female)	82.9	84.1	79.1	86.0
Professional contact with target group (%)				
Daily	29.0	7.2	38.2	33.6
Weekly	53.1	50.7	55.5	52.3
Monthly	17.1	40.6	6.4	13.1
Less often	0.7	1.4	0.0	1.9
Personal contact with target group (% yes)	67.1	70.6	74.0	63.2

Survey instrument

A TPB questionnaire was developed based on the recommendations of Ajzen (2002). The results of a study describing the possibilities and barriers experienced by Flemish VR counselors to implement IPS (Knaeps, DeSmet, & Van Audenhove, 2012) were used to generate items. The questionnaire has

been revised and adapted by an independent expert in constructing TPB questionnaires in order to ensure face and content validity of the instrument. In addition, an expert panel consisting of five VR counselors working with people with SMI revised the 46-item questionnaire. During the development and revision of the instrument, one item measuring attitudes was deleted (i.e., 'A focus on competitive employment has consequences for my own work'). Two additional revisions concerned the PBC measure, i.e. the answer categories of the scale were reformulated (from '1= totally not agree to 6= totally agree' to '1= never to 6= always') and some examples were included to enhance clarity of barriers (e.g., downsizing, lack of support).
The questionnaire was electronically distributed using an online survey platform. Anonymity was guaranteed.

Parallel with other studies, the correlations between the belief measures of each determinant are reported. In addition, aggregated measures were calculated. For the attitude, subjective norm and PBC-measures, the product of the belief measures for each determinant (e.g., first item of belief strength and of outcome evaluation) was calculated. For self-efficacy a sum-score was calculated. Cronbach's alphas for these aggregated measures are reported. However, the items and not so much the scales or relationships between items are the key point of interest in this study (Gagné & Godin, 2000).

Attitude

The assessment of behavioral beliefs towards competitive employment is based on seven reported outcomes of competitive employment (Knaeps et al., 2012): (1) integration in society, (2) higher income, (3) more self-confidence, (4) higher level of autonomy/independency, (5) more stress, (6) less prejudices/stigma in society, and (7) temporary worsening of psychiatric symptoms. As these seven outcomes were used to measure belief strength and outcome evaluation, the measurement of behavioral beliefs included 14 items. 'Belief strength' is measured by asking how often each of the seven outcomes of competitive employment occurs on a 6-point Likert scale (1 = not at all likely to 6 = very likely). An example of an item is "How often competitive employment does increase a persons' autonomy". 'Outcome evaluation' is the desirability of each outcome of competitive employment. Respondents rated on a 6-point Likert scale (1 = very negative to 6 = very positive) whether each outcome is rather positive or negative for the person (Ajzen, 2002a). An example is: "How positive is achieving more autonomy for most people with SMI?". The attitude measures correlated significantly (r= .605, p<.001). The product items formed an internal consistent attitude measure (α = 0.77).

Subjective Norm

Subjective norms constitute of normative belief strength and motivation to comply. To measure normative belief strength, respondents rated for each of four groups (client, colleagues, supervisor/boss and others outside work, e.g., partner, friends, parents) how often a particular group considers competitive employment important (e.g., "The client with SMI thinks I should focus on competitive employment.") (1 = never to 6 = always). Respondents subsequently registered on a 6-point Likert scale whether they will comply with the opinion of each of the four groups (1 = not at all likely to 6 = very likely). In total, the assessment of subjective norms includes 8 items. The two measures correlated significantly (r= .379, p<.001). The product items formed an internal consistent subjective norm measure (α = 0.77).

Perceived Behavioral Control and Self-Efficacy

Previous research identified eight barriers that might interfere with focusing on competitive employment (Knaeps et al., 2012): (1) socio-economic problems (housing, transportation, debts…), (2) instable psychiatric symptoms, (3) lack of time for follow-up, (4) negative internal organizational affairs (e.g., downsizing, lack of support), (5) insufficient contact with employers, (6) incompatible legislation, (7) lack of motivation of the client and (8) insufficient collaboration with other services (e.g., with mental health services, or local governmental organizations). These eight barriers were used three times in order to measure control belief strength, power and self-efficacy. 'Control belief strength' is assessed by rating the likelihood each of these barriers occurs (6-point Likert scale from 1 = never to 6 = always). An example of an item is "How often is there a lack of time for follow-up?" 'Control belief power' is measured by the difficulty each barrier poses on rehabilitation (6-point Likert scale from 1 = very difficult to 6 = very easy). An example of an item is "How difficult is it to focus on competitive employment when there is a lack of time for follow-up?". The PBC measures correlated significantly (r= -.246, p<.001). Cronbach's alpha for the product items is rather low (α = 0.68), which is not surprising as it is already reported in several studies that PBC scales tend to have a low internal reliability (Askelson, Campo, Lowe, Dennis, Smith, & Andsager, 2010; Grunfeld, & Kohli, 2010; Hong, Gittelsohn, & Joung, 2010; Klöckner, & Matthies, 2009; Roncancio, Ward, & Fernandez, 2013).

'Self-efficacy' was also rated on a 6-point Likert scale with each respondent indicating their confidence to overcome each barrier (1 =not at all confident to 6 = very confident). Self-efficacy correlated highly with control belief strength (r= -.279, p<.001) and control belief power (r= .164, p=.005). The items of self-efficacy formed an internal consistent measure (α = 0.79).

Data analysis

For each of the determinants of intention, data was analyzed by one-way ANOVA's. When significant differences occurred, post-hoc comparisons using t-tests were carried out. A Bonferroni correction was used to allow for the type I error inflation when conducting multiple comparisons (Zar, 1984). All analyses were conducted using SPSS statistics version 17.0 (Chicago: SPSS Inc).

Results

One-way analysis of variance showed a number of differences regarding attitude, normative beliefs, perceived barriers and self-efficacy of the three groups of counselors. Age, contact with the target group and length of service had no significant effect on the outcomes and are therefore not further described.

Attitude

Concerning behavioral belief strength, all counselors specify that competitive employment results in more integration in society (*M*= 4.47, *SD*= 0.90), more self-confidence (*M*= 4.30, *SD*= 0.91), a higher income (*M*= 4.27, *SD*= 0.96) and more autonomy (*M*= 4.03, *SD*= 0.90) for people with SMI (Table 2). It sometimes results in higher levels of stress (*M*= 3.79, *SD*= 0.77) and worsening of symptoms (*M*=3.20, *SD*= 0.55). The three groups of VR counselors seem to differ concerning some of their behavioral beliefs. VR specialists and case managers think competitive employment will (very) often lead to self-confidence ($F(2, 283)= 7.69$, $p= .001$), autonomy ($F(2, 283)= 11.92$, $p<.001$) and integration in society ($F(2, 283) = 7.08$, $p=.001$) whereas gatekeepers indicate that these results occur only occasionally and that income is the most prevalent effect.

Regarding the outcome evaluation, all three types of counselors rate the worsening of symptoms (*M*= 2.57, *SD*= 0.87) and increased levels of stress as the most negative outcomes of competitive employment. In contrast, more integration in society (*M*= 4.76, *SD*= 0.76), income (*M*= 4.78, *SD*= 0.75) and self-confidence (*M*= 4.84, *SD*= 0.73) are evaluated as rather positive. Case managers and VR specialists rate higher levels of autonomy ($F(2, 283)=6.16$, $p= .002$) and self-confidence ($F(2, 283) = 7.63$, $p= .001$) more positive than gatekeepers.

Table 2. Behavioral belief and outcome evaluation (1-6) (M, SD)

Items	All		Gatekeepers (1)		Case managers (2)		VR specialists (3)		F	P	Post hoc Comparison
	M	SD	M	SD	M	SD	M	SD			
Behavioral belief strength											
Integration in society	4.47	0.90	4.13	0.91	4.53	0.91	4.63	0.83	7.08	.001	1<2, 1<3
More self confidence	4.30	0.91	3.96	1.02	4.32	0.85	4.50	0.85	7.69	.001	1<2, 1<3
Higher income	4.27	0.96	4.35	0.97	4.25	0.90	4.24	1.01	0.31	.736	
Higher level of autonomy	4.03	0.90	3.64	0.80	4.02	0.88	4.29	0.89	11.92	<.001	1<2, 1<3
More stress	3.79	0.77	3.75	0.79	3.85	0.78	3.76	0.75	0.46	.633	
Less prejudices, stigma in society	3.79	1.05	3.67	0.97	3.86	1.07	3.80	1.09	0.75	.475	
Temporary worsening of symptoms	3.20	0.55	3.17	0.62	3.23	0.48	3.18	0.58	0.29	.749	
Outcome evaluation											
Integration in society	4.76	0.76	4.57	0.78	4.85	0.77	4.79	0.74	3.08	.047	†
More self confidence	4.84	0.73	4.55	0.88	4.95	0.66	4.93	0.64	7.63	.001	1<2, 1<3
Higher income	4.78	0.75	4.71	0.81	4.86	0.71	4.74	0.74	1.16	.315	
Higher level of autonomy	4.50	0.68	4.26	0.72	4.53	0.63	4.62	0.67	6.16	.002	1<2, 1<3
More stress	2.68	0.87	2.70	0.88	2.60	0.86	2.75	0.87	0.80	.449	
Less prejudices, stigma in society	4.45	0.92	4.36	0.91	4.53	0.89	4.43	0.97	0.72	.487	
Temporary worsening of symptoms	2.57	0.87	2.54	0.80	2.51	0.82	2.65	0.96	0.82	.441	

Note. Only significant differences at the .01 level are showed for the post hoc comparisons using Bonferroni correction

† no longer significant after Bonferroni correction

Subjective norms

Concerning the normative belief strength, counselors think that their clients (*M*= 4.11, *SD*= 1.00) and supervisors (*M*= 3.91, *SD*= 0.77) would appreciate their focus on competitive jobs (Table 3). Of the three types of counselors, VR specialists are most convinced that their clients ($F(2,283) = 41.19$, $p<.001$), colleagues ($F(2,283) = 54.80$, $p<.001$) and supervisor ($F(2,283) = 51.71$, $p<.001$) value a focus on competitive jobs.

The three types of counselors are most motivated to comply with the desires of their clients (*M*= 5.14, *SD*= 0.77). Especially VR specialists are likely to comply with their desires ($F(2, 283) = 8.94$, $p<.001$). Moreover, VR specialists are -compared to gatekeepers- more inclined to take into account the opinions of their supervisor ($F(2, 283) = 11.12$, $p<.001$) and colleagues ($F(2, 283) = 10.09$, $p<.001$), albeit not significantly more than case managers.

Perceived Behavioral Control and Self-efficacy

Regarding the control beliefs, all three groups of counselors indicate that socio-economic issues (*M*= 3.94, *SD*= 0.69) and instable psychiatric problems (*M*= 3.80, *SD*= 0.67) are significant impediments for attaining competitive employment (Table 4). The counselors perceive sufficient collaboration with other services (*M*= 2.77, *SD*= 0.92). Furthermore, the three groups of counselors differ significantly in their control belief strength. Gatekeepers and case managers perceive more lack of time for follow-up ($F(2, 283) = 14.24$, $p<.001$) and insufficient collaboration with employers ($F(2, 283) = 32.41$, $p<.001$) compared to VR specialists. Gatekeepers also perceive a significant higher rate of unmotivated clients ($F(2, 283) = 14.19$, $p<.001$) and incompatible legislation ($F(2, 283) = 5.00$, $p= .007$) in contrast with case managers and employment specialists. Finally, gatekeepers perceive more negative internal barriers (e.g., downsizing, lack of support) compared to VR specialists ($F(2, 283) = 9.10$, $p<.001$).

With respect to the control belief power, all counselors believe that instable psychiatric symptoms (*M*= 1.67, *SD*= 0.68) and a lack of motivation (*M*= 1.64, *SD*= 0.74) mostly hinder them in guiding and supporting the person with SMI towards competitive employment. A lack of time for follow-up ($F(2, 283) = 15.43$, $p<.001$), insufficient contact with employers ($F(2, 283) = 5.18$, $p= .006$) and incompatible legislation ($F(2, 283) = 9.74$, $p<.001$), are a greater hinder for gatekeepers compared to case managers and VR specialists.

All counselors indicate relatively high levels of self-efficacy on collaboration with other services (*M*= 4.40, *SD*= 0.92) and working with people with less stable psychiatric symptoms (*M*= 4.20, *SD*= 0.81). Negative internal affairs in their own organization (e.g., downsizing, lack of support) (*M*= 3.70, *SD*= 0.95) and incompatible legislation (*M*= 2.65, *SD*= 1.03) are harder hurdles to overcome.

Many differences exist with regard to self-efficacy among the three groups. First, all groups differ regarding their sense of self-efficacy when there is a lack of time for follow-up (F(2, 283) = 20.60, p<.001) and insufficient contact with employers (F(2, 283) = 40.40, p<.001). In these cases, VR specialists experience the highest self-efficacy levels. Second, case managers and VR specialists experience more self-efficacy compared to gatekeepers in handling socio-economic problems (F(2, 283) = 7.71, p= .001), tackling internal affairs (F(2, 283) = 13.28, p<.001) and increasing collaboration with other services (F(2, 283) = 7.34, p= .001). Finally, there are significant differences in self-efficacy between gatekeepers and VR specialists (F(2, 283) = 3.98, p= .020) in dealing with clients' instable psychiatric symptoms.

Table 3. Subjective norms and differences between subjective norm beliefs (1-6) (M, SD)

Items	All		Gatekeepers (1)		Case managers (2)		VR specialists (3)		F	P	Post hoc Comparison
	M	SD	M	SD	M	SD	M	SD			
Normative belief strength											
Client	4.11	1.00	3.33	1.02	4.16	0.84	4.56	0.82	41.19	<.001	1<2<3
Supervisor, boss	3.91	1.16	3.14	1.09	3.67	0.94	4.64	0.99	51.71	<.001	1<2<3
Colleagues	3.61	1.17	2.90	0.96	3.31	0.91	4.38	1.10	54.80	<.001	1<2<3
Partner, significant others outside work	2.79	1.26	2.62	1.16	2.69	1.13	2.99	1.42	2.31	.101	
Motivation to comply											
Client	5.14	0.77	4.96	0.93	5.03	0.70	5.38	0.67	8.94	<.001	1<3, 2<3
Supervisor, boss	4.52	0.77	4.16	0.85	4.61	0.71	4.67	0.71	11.12	<.001	1<2, 1<3
Colleagues	4.52	0.81	4.16	0.92	4.59	0.75	4.68	0.72	10.09	<.001	1<2, 1<3
Partner, significant others outside work	2.44	1.31	2.26	1.35	2.31	1.21	2.69	1.36	3.22	.041	†

Note. Only significant differences at the .01 level are showed for the post hoc comparisons using Bonferroni correction

† no longer significant after Bonferroni correction

Table 4. Differences between control beliefs and self-efficacy (1-6) (M, SD)

Items	All		Gatekeepers (1)		Case managers (2)		VR specialists (3)		F	P	Post hoc Comparison
	M	SD	M	SD	M	SD	M	SD			
Control belief strength											
Socio-economic problems	3.94	0.69	3.97	0.77	4.04	0.68	3.81	0.65	2.97	.053	
Instable psychiatric symptoms	3.80	0.67	3.84	0.63	3.87	0.65	3.69	0.71	2.19	.114	
Lack of time for follow-up	3.68	1.19	4.16	1.17	3.79	1.11	3.25	1.14	14.24	<.001	3<1, 3<2
Negative internal organizational affairs	3.53	1.11	3.59	1.06	3.82	1.02	3.20	1.16	9.10	<.001	3<2
Insufficient contact with employers	3.52	1.04	4.01	1.08	3.75	0.88	2.95	0.91	32.41	<.001	3<1, 3<2
Incompatible legislation	3.21	0.97	3.52	1.01	3.09	0.97	3.12	0.90	5.00	.007	2<1, 3<1
Person with SMI is not motivated	3.10	0.67	3.43	0.70	3.09	0.58	2.91	0.67	14.19	<.001	2<1, 3<1
Insufficient collaboration with other services	2.77	0.92	2.90	1.02	2.68	0.91	2.77	0.85	1.19	.306	
Control belief power											
Socio-economic problems	2.12	0.77	2.19	0.91	2.11	0.72	2.08	0.73	0.40	.674	
Instable psychiatric symptoms	1.67	0.68	1.77	0.77	1.60	0.64	1.68	0.67	1.31	.272	
Lack of time for follow-up	2.79	0.80	2.35	0.74	2.92	0.76	2.94	0.76	15.43	<.001	1<2, 1<3
Negative internal organizational affairs	2.83	0.77	2.59	0.69	2.87	0.79	2.94	0.78	4.67	.010	1<3
Insufficient contact with employers	2.55	0.92	2.25	0.93	2.68	0.88	2.60	0.92	5.18	.006	1<2, 1<3
Incompatible legislation	2.75	0.84	2.38	0.89	2.85	0.83	2.89	0.73	9.74	<.001	1<2, 1<3
Person with SMI is not motivated	1.64	0.74	1.64	0.82	1.65	0.72	1.63	0.69	0.04	.960	
Insufficient collaboration with other services	2.77	0.99	2.61	0.97	2.86	1.00	2.77	0.98	1.42	.243	
Self-efficicay											
Socio-economic problems	3.75	0.91	3.39	1.03	3.92	0.81	3.80	0.87	7.71	.001	1<2, 1<3
Instable psychiatric symptoms	4.20	0.81	3.99	0.92	4.19	0.74	4.34	0.80	3.98	.020	1<3
Lack of time for follow-up	3.51	1.03	2.94	1.11	3.50	0.87	3.90	0.96	20.60	<.001	1<2<3
Negative internal organizational affairs	3.70	0.95	3.25	1.01	3.72	0.89	3.97	0.87	13.28	<.001	1<2, 1<3
Insufficient contact with employers	4.01	0.96	3.35	1.04	3.93	0.82	4.51	0.73	40.40	<.001	1<2<3
Incompatible legislation	2.65	1.03	2.45	1.13	2.79	1.02	2.64	0.94	2.37	.095	
Person with SMI is not motivated	4.13	0.70	4.03	0.75	4.11	0.67	4.21	0.69	1.58	.208	
Insufficient collaboration with other services	4.40	0.92	4.06	1.03	4.58	0.86	4.42	0.84	7.34	.001	1<2, 1<3

Note. Only significant differences at the .01 level are showed for the post hoc comparisons using Bonferroni correction

Discussion

This is the first study that addresses differences between VR counselors' underlying beliefs to focus on competitive employment for people with SMI. The TPB is used since it is (1) a well-known theory that makes it possible to form a comprehensive understanding of beliefs of people and (2) adaptable to local conditions. An in depth understanding of beliefs was thus acquired using the combination of this theoretical framework and prior findings about competitive employment beliefs of counselors (Knaeps et al., 2012).

To be able to offer integrated VR support, attitudes, norms, PBC and self-efficacy of different counselors need to be aligned. Yet, this study shows that VR counselors of different organizations differ in their underlying beliefs.

The three types of Flemish VR counselors differ in their behavioral beliefs on the benefits of competitive employment. Case managers and VR specialists believe that competitive employment often results in latent benefits such as increased integration, autonomy and self-confidence. In contrast, gatekeepers consider the manifest function (i.e., income) as the most recurrent and positive effect of competitive employment. However, entry in (low-paid) employment does not always result in higher income due to the strong social security system in Belgium.

Besides, Flemish VR counselors differ in the degree in which they perceive and comply with norms. The more specialized the VR counselors are, the more they perceive that others (i.e., clients, supervisors and colleagues) value a focus on competitive work (normative belief strength) and the more one is likely to comply with the others' desires. VR specialists even indicate their supervisors stronger value a focus on competitive work than their clients.

VR counselors also differ in the degree in which they perceive behavioral control over barriers. A lack of motivation of the client is more prevalent and hindering for gatekeepers as compared to case managers and VR specialists. In addition, gatekeepers experience higher rates of meso- and macro-level barriers (i.e., lack of time for follow-up, contact with employers and incompatible legislation). VR counselors report different levels of self-efficacy in handling these barriers. VR specialists experience more self-efficacy in dealing with the clients' socio-economic problems and instable psychiatric problems. VR specialists and case managers also report higher levels of self-efficacy as compared to gatekeepers for barriers on the meso-level (e.g., insufficient contact with employers or lack of time for follow-up).

Four factors may explain the differences in beliefs and practices among types of counselors, i.e., the structure of the organizations in which VR counselors work, the organizational culture, the focus of supervisors and the task characteristics of the job.

First, differences among types of counselors may be the result of the structure of the organizations in which they work. Gatekeepers work in the Public Employment Service, which is a large and bureaucratic organization. Such organizations are often characterized by strong hierarchical structures and formal decision-systems, relying on a high administrative efficiency and strict rules (Parker & Bradley, 2000). These structures and procedures do simplify the job, but appear to affect the perceived behavioral control of the Flemish employees. Moreover, these organizations operate under the influence of political decisions (Holmes & Karst, 1990). As gatekeepers are employed by the state, they are more subjected and bound to follow the legislation and procedures as compared to employees working in local and smaller organizations. This might explain why gatekeepers experience lower self-efficacy in overcoming some barriers such as incompatible legislation. VR specialists experience more control over barriers as they work in smaller organizations which are less strictly monitored.

The results can also be partially explained by the differences among services in organizational culture. In large federal or state organizations such as the Flemish Employment Service, employees are often less responsive to the wishes of stakeholders, in this case the client with SMI who has a desire to work (Jones, 2007; Parker & Bradley, 2000). The internal focus of such organizations also hinders the collaboration with other organizations and services. In addition, the strict rules and procedures in governmental organizations have a negative effect on the attitude towards divergent thinking and innovations such as the SE-model (Williams, 2004). This might result in gatekeepers who are less oriented to focus on competitive jobs for people with SMI.

Gatekeepers' supervisors are often generalists and thus have to take care of more diverse responsibilities. Therefore, they are less involved with their counselors and the counselors' specific clients. Previous research shows that supervisors' behaviors and attitudes influence the intentions, norms and attitudes of VR counselors (Bond et al., 2001; Gowdy, Carlson, & Rapp, 2003). This could explain why gatekeepers have a different attitude towards the IPS principle of focusing on competitive employment.

Two task characteristics, i.e., the amount of process- and outcome feedback VR counselors receive and the level of autonomy they experience can also clarify these results. As concerns the process feedback, case managers and particularly VR specialists have more enduring contact with the clients in comparison with gatekeepers. This prolonged contact and opportunity to interact with people with SMI enables them to experience a positive counseling process, which will strengthen their self-efficacy (Bandura, 2001). Less visible outcomes, such as increased integration into society, self-

confidence and autonomy might thus become more obvious. Specialized counselors indicate that these latent effects of competitive employment may be more valuable than an increase in income.
Regarding the outcome feedback, we notice that once the client is referred to specialized services, gatekeepers often lose contact with the person. Therefore, they are rarely informed about the final employment outcome. Information about outcomes is however crucial and contributes to involvement, realistic assessment of the own competences and motivation (Bakker & Demerouti, 2007; Murphy & Cleveland, 1995). When gatekeepers experience a lack of feedback about the final outcomes, they are more likely to rely on the overall -and often less positive- prevailing attitudes (Holmes & Karst, 1990) towards the benefits of employment and the outcomes of VR. Moreover, as in the case of a lack of process feedback, a lack of feedback on the final outcomes (e.g., finding a regular job) will not enable gatekeepers to develop their self-efficacy either (Bandura, 2001).
Lastly, within the smaller and more innovative teams of VR specialists, more training and autonomy to pro-actively handle barriers is offered. The higher level of autonomy may explain why they experience fewer barriers and why their levels of self-efficacy are higher.

We point to the limitations of this study and make some recommendations for future research. A first limitation concerns the generalizability of our results. As these findings originate from the specific Belgian VR system with its three different types of organizations, we cannot guarantee their full applicability in other countries. Yet, the Belgian VR system generally seems to resemble the VR system in other economically developed countries. In these countries, the VR system is supervised by a federal organization that is responsible for paying the benefits and offering overall gatekeeping services. Furthermore, in many countries smaller and regionally dispersed local VR services take up on-the-job support. Although each country has its own system, people with SMI thus go through different services before individualized evidence based services are offered (Becker et al., 1998; Premuda-Conti & Lewis, 2011). Therefore, we expect that our general results will hold in other countries as well. A second limitation is that self-reported beliefs were measured. Such beliefs may not always directly predict behavior. Apart from the TPB constructs, other factors such as habits, external or environmental barriers and personal intentions might interfere in explaining actual behavior (Montano, & Kasprzyk, 2008). Therefore, future research should take these factors into account in explaining the actual behavior. Another limitation concerns the relatively low response rate of gatekeepers. This low response rate might reflect differences in attitudes (i.e., in contributing to research on competitive employment for clients with SMI) but might also be attributed to other barriers such as a high caseload or negative attitude of the supervisor to participate in studies. Finally, this study did not explicitly examine the link between VR counselors' intentions to search for competitive jobs and those of clients. We recommend future research to study how differences in

attitudes, norms, PBC and self-efficacy of VR counselors affect the motivation and attitudes of clients. This is important because low expectations of VR counselors can lead to the advice of no longer focusing on competitive employment any more (Rinaldi et al., 2008). These low expectations held by counselors may be internalized by their clients, diminishing their motivation and hope (Rinaldi et al., 2008).

Implications for rehabilitation practice and education

Our findings suggest that counselors from different services have differing views and beliefs, which hinder their collaboration. This leads us to the conclusion that more integrated care services are needed as well as joint education, training and supervision.

In countries were multiple divisions of VR organizations exist, collaboration among organizations needs to be stimulated to strengthen positive attitudes and to share solutions for common problems. This is possible by co-locating VR counselors of different organizations, which makes it possible for gatekeepers to form an idea about the real employment outcomes, the benefits of work (e.g., integration, income) and the barriers that exist (Campbell et al., 2007; Fox, 2013; Rucci et al., 2012). Co-location makes it also possible to offer process feedback during face-to-face contacts between gatekeepers and more specialized counselors which will raise the motivation and involvement of counselors (Bakker & Demerouti, 2007). Another way to stimulate collaboration is to create knowledge sharing platforms. These platforms facilitate the sharing of ideas, methods and results of services and will in turn lead to more integrated services.

In the case of Flanders, Supported Employment is not yet widespread and the role of the SE counselor, incorporating both case management and on-the-job support, is not widely implemented. In line with the SE-model, it is important to merge case managers' and specialists' functions into one integrated function and to create strong and fluent collaboration lines between organizations. As a result, the client does not need to establish relationships with different counselors and he has one VR counselor who is responsible for the whole VR process.

A second practical implication concerns the education, supervision and training of VR counselors. It is important that counselors believe in the value of SE and its principle of focussing on competitive jobs. Yet, primary care professionals such as gatekeepers are often less trained in specific skills (Szymanski, 1991) and are less aware of evidence based practices (Ayanian et al., 1994). Training needs to equip those gatekeepers with both generalist and specialist competences (Ayanian et al., 1994; Fleming et al., 2013; Frost, Morris, Sherring, & Robson, 2010; Gowdy et al., 2004; Marshall, Rapp, Becker, & Bond, 2008). This will result in more positive attitudes towards evidence based practices such as SE (Gowdy et al., 2004) and ultimately lead to higher referral rates and employment

outcomes (Bond et al., 2001; Gowdy et al., 2004; Marshall et al., 2008; Torrey, Bond, McHugo, & Swain, 2012). Another important way to generalize an attitude-shift is the hiring of supervisors who are motivated and who stress strengths-based practices as an explicit part of SE. It are often supervisors who make the difference between high performing and low performing evidence based programs (Gowdy, Carlson, & Rapp, 2004). In Flanders, no formal training of VR counselors exists. More formal and academically supported trainings need to be elaborated on as these will make it possible to spread state of the art knowledge. In addition, policy makers need to reduce caseloads and establish longer follow-up of clients and their employers.

Conclusions

Using the TPB as a framework, this study shows many differences among the three types of VR counselors in their perception of competitive employment. The more specialized counselors are, the more benefits of competitive jobs for clients with SMI they perceive and the fewer barriers they experience. To improve the integrated service for clients, offering training to VR counselors, increasing outcome feedback and enhancing intersectoral communication is crucial.

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Chapter 8

General discussion

Employment is for many people with (severe) mental illness (SMI) a valuable way to attain full citizenship. Participation in employment can result in improved welfare, well-being and it may facilitate the overall process of recovery (Dunn et al., 2008; Perkins et al., 2009). Until now, many people with SMI remain unemployed or are out of the labor force (OECD, 2012). Hence, it is important to offer effective vocational rehabilitation (VR) services by high-skilled and motivated professionals. This can be done by offering the evidence-based Individual Placement and Support-model (IPS) (Becker & Drake, 1994; Kinoshita et al., 2013; Twamley et al., 2003). IPS stresses some key principles, i.e., zero-exclusion, working with clients' preferences, quick job searches, focusing on competitive employment, collaboration between mental health and VR services, benefits counseling and supporting employers (Becker & Drake, 1994; Bond, 2004; Kinoshita et al., 2013; Marino & Dixon, 2014).

The principles of working with clients' preferences, zero-exclusion and quick job searches are founded on the fact that working towards difficult goals succeeds better when people are motivated. Although IPS stresses that VR can start during hospitalization, there is little tradition in Belgian psychiatric hospitals to focus on VR. To start the VR process during hospitalization, it is essential that patients are motivated to work and that mental health practitioners consider employment important and realistic. Prior research indicated that professionals may doubt (competitive) employment for people with mental disorders. In addition, it is important that mental health practitioners and VR counselors join forces (Van Weeghel et al., 2013). In the case of hospitalization, the VR counselor can continue the process using the information gathered during the hospitalization. Yet, few successes can be expected when the VR counselor does not believe in the possibility of people with SMI to work and do not want to focus on such jobs.

Many questions remain concerning the vocational goals of hospitalized patients, the level of consensus with their personal mental health practitioner and the intentions of VR counselors. This doctoral research thus focused on these stakeholders. Our **first main objective** was to study the vocational goals, barriers and needed support of people currently receiving little VR attention, namely hospitalized patients. We also wanted to know what their counselors think is realistic for their patients and whether both agree on barriers to employment and steps to overcome barriers. Our **second main objective** was to study VR counselors' intentions and to create a framework that explains their intentions. Such a framework was lacking but highly needed to adapt current training programs and organization of services (Drebing et al., 2012; Goscha et al., 2013).

In this general discussion, we will offer a synthesis of the key findings of the empirical studies presented in the previous chapters. Next, some strengths and limitations of the research are discussed after which we will describe some future research perspectives based on the results and the available literature. The chapter concludes with some recommendations.

1. Key findings

We will first answer the research questions of the study of hospitalized patients and their mental health practitioners. Next, we elaborate on the findings of our studies concerning VR programs and counselors' intentions to focus on competitive jobs for people with SMI.

1.1 Hospitalized patients and their mental health practitioners

We conducted a cross-sectional study in seven psychiatric hospitals of hospitalized patients' vocational goals and the perspectives of mental health practitioners. The **first research question** was **"What are the vocational goals of hospitalized patients with mental disorders in the short and in the long term?"**. We noticed that 36% and 45% of hospitalized patients want a competitive job, respectively in the short and long term. Other often stated goals are voluntary work (14.6% on the long term) and Sheltered Employment (10.4% on the long term). This percentage interest in competitive employment is comparable to the study of Mc. Quilken et al. (2003) reporting an interest of 46% of people suffering from SMI. Moreover, the interest is higher than the interest of a representative group of people with SMI using out-patient services in the Netherlands (33%) (Place, Hulsbosch, & Michon, 2014; Van Weeghel et al., 2013). Yet, most studies report percentages ranging between 70 and 90% and interest in our sample seems thus rather low (Rogers, Walsh, Massotta, & Danley, 1991; Secker & Gelling, 2006; Van Audenhove & Wilmotte, 2004).

If we want to make comparisons with other groups of people with disabilities, there is only one study that addresses this (Ali, Schur, Blanck, 2011). The results of this study show that 90% of people with 'mental impairments' (i.e., having any emotional or mental disability) want a paid job now or in the future. This number is higher compared to other groups such as people with no disability (77.5%), visual impairment (74.8%), hearing impairment (85.7%) or mobility impairment (79.2%).

Although we are now comparing results across studies and across groups of people, such comparisons need to be made with caution due to a number of reasons. First, previous studies assessed vocational interest of mostly non-hospitalized clients of community-based programs in the United States (US) or the United Kingdom (UK) (Coursey et al., 1991; McQuilken et al., 2003; Secker et al., 2001; Secker & Gelling, 2006). In these countries, less people are hospitalized due to the

availability of community-based programs. In these settings, there is more attention for VR and thus motivation and hope are fostered. In Belgium, people are more often hospitalized and there is a lack of attention for VR during hospitalization. Second, some of the international studies comprised people already receiving VR services and thus created a bias as these programs often require an a priori interest in competitive employment (Becker et al., 1998; Becker et al., 1996; Secker et al., 2001; Van Audenhove & Wilmotte, 2004). Due to this, it is evident that studies find high competitive employment interest. Thirdly, no valid and reliable measures of vocational interest exist. Results are difficult to compare as studies used different questions including:

- Do you want to change your employment status? (Rogers, Walsh, Massotta, & Danley, 1991)
- 'If you are interested in work, what is most of use for you now?' (multiple options) and 'Indicate which of the options is your long-term goal? (Secker, Grove, & Seebohm, 2001)
- 'Choose what is appropriate: not working and do not want to work / not working, want to work, but not looking / not working, but actively seeking employment / currently working' (McQuilken et al., 2003)
- 'If you are not in paid work, are you interested in obtaining work?' (yes now-maybe in the future-no) (Secker & Gelling, 2006)
- Would you like to have a paid job, either now or in the future? (Ali, Schur, & Blanck, 2011)

Even when we do not compare our results with other studies and we take into account that our sample also included people with SMI that need long-term in-patient treatment and care, the competitive employment interest of 45% of hospitalized patients can be stated as relatively low compared to what can be expected from the overall population. This can be attributed to several factors.

Firstly, according to the 'interpersonal expectancy effect', the attitudes and behaviors of mental health practitioners influence these of their patients (Baruch et al., 2009; Harris & Rosenthal, 1985; Rinaldi & Perkins, 2005). Therefore, we assessed what the key mental health practitioner found realistic for his/her patient **(research question two: "Which vocational goals do mental health practitioners perceive as realistic for their patients?"** and **research question three: "What is the level of agreement between patients and practitioners concerning competitive jobs?")**. Our results indicate that many practitioners perceive competitive employment as less realistic compared to Sheltered Employment, volunteering or day activity centers. Moreover, they are less optimistic concerning competitive employment than their patients. By this, practitioners can create a viscous circle of low expectations (Rinaldi & Perkins, 2005; Rinaldi et al., 2008) as they will encourage and explore competitive employment goals less or refer more to pre-vocational services instead of services that focus on competitive jobs (Shima et al., 2008). These behaviors and expectations will

influence patients; they will expect vocational failure by which they set less competitive employment goals (Goscha et al., 2013; O'Connell & Stein, 2011). This effect is called the interpersonal expectancy effect. The attitudes and behavior of both the patient and the practitioner will ultimately result in reduced competitive employment rates. This acts as a self-fulfilling prophecy because it seems to confirm the counselors' and patients' perceptions that competitive employment is unrealistic (O'Connell & Stein, 2011; Rinaldi et al., 2008). In contrast, and in accordance with the tenets of the recovery paradigm, practitioners must express their hope for the future of the patients. Much is realistic, even when taking into account the limitations caused by illness (Gruhl, 2005). By doing this and by reframing hard experiences during the VR process as opportunities, patients are stimulated to develop new meaning and purpose in their life.

Secondly, employment is one of the most frequently reported areas of perceived and anticipated discrimination (Lasalvia et al., 2013; Thornicroft et al., 2009). This may inhibit people to apply for jobs or to show up on job interviews.

In addition, disability policies in Belgium may discourage people to find jobs because income by benefits is sometimes higher than income by employment (OECD, 2013b).

Also, as work demands are increasing (Corvers & Van Hootegem, 2014), it is possible that people with mental illness do no longer believe that competitive employment is realistic for them. Luckily, evidence-based practices can help to overcome some of these barriers by benefits counseling, job-carving, supporting employers and on-the-job coaching (Becker & Drake, 1993).

Lastly, the samples of US or UK studies did not comprise people with the most severe mental illness that - irrespective of the country - need to be hospitalized because their illness is profound. We did include them but because these patients experience such severe disruptions and low well-being, employment may not likely to be a primary interest.

Besides different views concerning vocational goals, there seems to be some differences in perspectives concerning vocational barriers and needed support **(research question three: "What is the level of agreement between patients and practitioners concerning: competitive jobs / employment barriers / steps to overcome barriers?")**. Practitioners perceive more vocational barriers to employment compared to their patients, which confirms the results of the only prior comparative study of this topic (Harris et al., 2014). Differences can be the result of a lack of insight by the patient (Goldberg, Green-Paden, Lehman, & Gold, 2001) or the practitioner's unawareness of the skills of their patients (Harris et al., 2014; Slade, 1994). When the practitioner does not have the skills or the time to assess how patients performed in former jobs, they may perceive more barriers than are actually present (Harris et al., 2014).

As expected, patients and practitioners also disagree concerning which intensive vocational support, such as on-the-job coaching, is needed. Although proven to be successful (Kinoshita et al., 2013), the total number of people (both practitioner and patient) choosing on-the-job coaching is rather low. This may be partially explained by the lower competitive employment interest (research question 1), the lack of knowledge concerning evidence-based VR or the lack of a large-scale offer of effective on-the-job coaching. Besides, stigmatizing views towards mental health disorders make it difficult for an employee to disclose such problems. This is however often needed to get the most effective on-the-job coaching.

In sum, there is a lack of agreement between practitioners and patients and this can have negative effects on the relationship and on the working alliance. This will ultimately affect the subsequent relationship with the VR counselor (Catty et al., 2010; Catty et al., 2011): when the patient experiences a lack of encouragement and support from the mental health practitioner, the patient will be less likely to form a relationship with the VR counselor albeit crucial to become employed (Catty et al., 2010; Catty et al., 2011).

1.2 VR counselors' focus on competitive employment

To attain high competitive employment outcomes, it is important that VR counselors endorse the philosophy and principles of the evidence-based IPS model (Gowdy et al., 2003) which stresses the importance of the focus on competitive jobs (Bond, 2004).
In a first explorative study, we checked which IPS-principles are implemented in different VR programs **(research question 4)** and which barriers to focus on competitive jobs exist **(research question 5)**.
Next, we created a theoretical framework of VR counselors' intentions to focus on competitive jobs **(research question 6)**. In addition, we studied differences between VR counselors of different organizations on their underlying beliefs concerning competitive employment **(research question 7)**. No framework of what determines counselor' focus on competitive jobs exists and thus current training programs or supervision of counselors may be inadequate.

1.2.1 IPS fidelity and barriers

The **fourth research question**, **"Do VR services implement IPS principles?"** was answered using the IPS-Scale. The results show that few organizations in the sample implement evidence-based principles. Consistent with a previous study (Bond, 2002), we found (i) a lack of integration between

VR organizations and mental health teams, (ii) a delayed search for competitive jobs and (iii) a lack of individualized job searches. Individualized jobs searches entails that one looks at clients' preferences rather than looking at which jobs are available in the community or at befriended organizations. Without taking the preferences into account, people working in Sheltered Employment who wish a regular job will not be heard. This may be the case as the transfer rate to competitive employment is often as low as 3% (Shima et al., 2008a; Vanderpoorten, 2010).

Using thematic analyses of semi-structured interviews of VR counselors we answered the **fifth research question** of the doctoral research: **"Which barriers to focus on competitive jobs are experienced by VR services?"**. Barriers can be categorized on three intertwined levels: the client level, the level of services and the environmental level. Most counselors attribute barriers to external factors on the environmental and client level, e.g., a lack of motivation or psychological ill-being of the client and inconsistent regulations. Fewer barriers were reported on the level of 'the services' which may indicate that counselors are in a process of external attribution ("Compared to others (clients, employers), we are less responsible for the low competitive employment outcomes."). External attribution may lead to pessimistic perspectives, feelings of hopelessness and a lack of behavioral control (Injeyan et al., 2011). Moreover, the counselor may negatively influence clients' hope and expectations (Rinaldi, Miller, & Perkins, 2010; Rinaldi & Perkins, 2005; Taylor & Bond, 2014).

By using the IPS scale and elaborating on the IPS principles in centers focusing on pre-vocational counseling and Sheltered Employment, the researchers also contributed to raising awareness of this evidence-based practice.

1.2.2 VR counselors' intentions to focus on competitive jobs

To answer the questions concerning VR counselors' intentions to focus on competitive employment we made use of an extended version of the Theory of Planned Behavior (TPB), including attitudes, social and moral norms, perceived behavioral control, self-efficacy and prior behavior **(research question 6, figure 8, page 24, full frame)**. In addition, belief-based measures of variables were used to study whether differences between counselors of different organizations exist **(research question 7, figure 8, page 24, dotted frame)**.

A. Intentions of VR counselors

The **sixth research question** was answered using confirmatory factor analysis and structural equation modeling of an extended TPB-framework. In the next paragraphs we aim (i) to describe the overall framework and (ii) to answer some questions regarding the framework.

Overall framework

The resulting model parallels an extended Theory of Reasoned Action (TRA). Perceived behavioral control (PBC) and self-efficacy proved not strongly associated with intentions. Hence, the high-valued focus on competitive jobs is determined by norms, attitudes and prior behavior.

First and foremost, counselors intend to focus more on competitive jobs when they experience that the social norm describes them to do so and/or when they experience an intrinsic and moral obligation. In other words, counselors are influenced by what others think is important, by what others expect them to do or what is experienced as morally right. Counselors are also more likely to focus on competitive jobs when they perceive competitive jobs as positive and when they have prior experiences with focusing on and finding such jobs. The effect of attitudes suggests that being conscious of the latent and manifest benefits of employment can increase counselors' focus on competitive jobs. It also means that this research shows that the IPS-principle of 'a focus on competitive employment' may not be merely interpreted as 'counselors need to have positive attitudes'. In the case counselors perceive disadvantages of competitive jobs for people with SMI (negative attitudes), they may still focus on such jobs if important others motivate or expect them to do so.

Targeting the abovementioned variables may increase the counselors' focus on competitive employment for people with SMI during career guidance and counseling. It is for example important that VR counselors receive feedback from their clients on how employment has improved their well-being and welfare. Training programs also need to include persuasive communication; motivate and stimulate people to think about moral norms and the positive consequences of employment. Counselors need to 'belief and feel' that their job activities help other people to improve their well-being. Finally, supervisors are recommended (1) to acknowledge their influence and role, (2) to express their support for VR counselors and (3) to adopt a goal-focused approach, expecting staff to do the same (Gowdy et al., 2004; Marshall et al., 2008). For this, supervisors need to be trained in effective team management and communication skills.

Questions regarding the framework

Is the strong effect of norms on intentions not inconsistent with previous TPB-studies? Social norms are often a weak predictor of intentions (Armitage & Conner, 2001). Yet in this study, there is a strong effect of 'overall norms', norms constitute of both social and moral norms. This may have enlarged the effect norms have in the study compared to other studies only incorporating social norms. Moreover, in the specific field of VR counseling it was already noticed that 'others' play an

important role during VR guidance (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; O'Brien et al., 2003; Rapp et al., 2008). This is certainly the case within IPS-support because IPS stresses working with the person's goals. The counselor actively questions and tries to act upon the preferences of the person. It is thus evident that counselors are influenced by their goals. Yet, this is not a sufficient reason to explain the strong effect of norms as our explorative study showed that VR counselors do not always focus on clients' goals. The effect of norms needs to be partially explained by the influence of colleagues and supervisors. They were also included in the questionnaire as important referents for the VR counselor. In parallel with other studies on VR, colleagues and supervisors seem to have an influence on counselors' behaviors and thus employment outcomes (Gowdy, Carlson, & Rapp, 2004; van Erp et al., 2007).

Why are social and moral norms one factor although previous research often find moral norms correlated with attitudes or independently predicting intentions (Kaiser, 2006; Kaiser & Scheuthle, 2003; O'Connor & Armitage, 2003)? Moral norms might be closely related to social norms due to the fact that the United Nations, Europe and groups of user representatives are increasingly asking to include people with mental disorders into the regular workforce just as once was done for people with physical challenges. As a result of these calls for more inclusiveness, counselors may be increasingly convinced of the moral value to focus on competitive jobs. Yet, because relatively few people became competitively employed until now and due to the lack of process- and outcome feedback, VR counselors did not yet fully experience the positive effects of competitive employment. As these benefits are represented by attitudes in the TPB, it explains why moral norms and attitudes are less strongly correlated in our study.

Wouldn't measuring prior behavior be sufficient as this is often related to future behavior? It has been argued that other TPB-variables are unnecessary because studying past behavior should be sufficient to predict future behavior (Bamberg, Ajzen, & Schmidt, 2003). In other words, behaviors might become solely determined by one's past behavior, rather than by cognitions such as those described in the TPB. In these cases, behavior is seen as a habit, a behavior performed as was done in the past and without much volitional reasoning. Thus, when prior behavior is found to be only linked to current behavior, it is no longer a reasoned behavior but a habit (Conner & McMillan, 1999). Yet, studies indicate that prior behavior does not predict all variance of later behavior and that it is associated with intentions as well (Armitage & Conner, 2001; Callahan, Hooper, Thayer, Magnan, & Bryan, 2013; Conner, Warren, Close, & Sparks, 1999; Mari, Tiozzo, Capozza, & Ravarotto, 2012; Ouellette & Wood, 1998). The construct of intentions is part of the TPB's reasoned variables in which volitional control is present.

Even in the case that actual behavior is most strongly associated with prior behavior, it may be that this direct link merely demonstrates a stability of behavior with the same factors determining behavior on both occasions (Bamberg et al., 2003; Elliott, Armitage, & Baughan, 2003). This temporal stability reveals little about the factors that are responsible for the stability. Besides, when one factor that determines the behavior changes, the person may no longer perform as usual (habitually). Thus, it remains interesting to study these key social cognitive factors, i.e., attitudes, norms and behavioral control (Bamberg et al., 2003; Conner et al., 1999), as was done in this study. We showed that prior behavior has a role; counselors with previous similar experiences are more inclined to focus on competitive jobs in the future. This finding addresses the importance of sufficient training and experiences before a VR counselor becomes responsible for clients.

What about the variables Perceived Behavioral Control (PBC) and self-efficacy? Both were not included in the model. In parallel with many studies, PBC did not prove a strong predictor of intentions (Armitage & Conner, 2001) probably because PBC is not a good measure of the actual control people experience. It may also be that PBC does not influence VR counselors' intentions but that it does predict actual behavior. To know this, future studies need to take up a measure of actual behavior. As we foresaw the minor role of PBC, we added self-efficacy. Many studies found it successfully replacing/supplementing PBC. This study also found no significant association between intentions and self-efficacy, i.e., counselors' intentions are not strongly related to how they feel able to overcome barriers. Although several methodological and theoretical explanations exist, we think that a belief-based measure of self-efficacy incorporating different specific beliefs would have resulted in a better measure of self-efficacy and may have revealed a link with intentions.

Can other models than the TPB-model be used as well? Yes. As we explained in chapter 3, there are many other models that can be used to study counselors' intentions or behavior. We chose the TPB-model because it offers an overall (general measures) and in-depth (belief-based measures) insight into the intentions under study. Moreover, we already added some promising variables and we thus used a TPB+-model. Until now, no framework existed and we needed to start with a model that offers a first but profound insight. This model can now be further tested and improved by adding additional variables.

B. Underlying beliefs

By using the TPB-framework we were able to gain a more profound insight into the beliefs of different counselors: (1) gatekeepers of the Flemish Public Employment Service (VDAB), (2) case managers of the Vocational Training Agencies (GTB), and (3) VR specialists of the Vocational

Counseling Centers (GOB). These counselors need to be aligned when supporting people with SMI in order to offer integrated VR support and continuous counseling. Yet, the current study showed that VR counselors of the three major organizations differ in their underlying beliefs **(research question 7)**.

Firstly, they differ on the benefits of competitive employment. More specialized counselors (case managers and VR specialists) believe that competitive employment often results in latent benefits such as increased integration, autonomy and self-confidence. In contrast, gatekeepers consider this to be less often the case. They perceive increased income as the most recurrent and positive effect of competitive employment. As employment does not always result in higher income due to the strong social security system, counselors need to be cautious to motivate people with the statement that their income will increase. This is why IPS recommends benefits counseling, i.e., determining the financial benefit/disadvantage of returning to work (Becker & Drake, 1994).

Secondly, VR counselors seem to differ in the degree in which they perceive and comply with norms. The more specialized the VR counselors are, the more they perceive that others value a focus on competitive work and the more they are likely to comply with others.

Thirdly, counselors experience different levels of control over barriers and different levels of self-efficacy to overcome barriers. Gatekeepers experience higher rates of meso- and macro-level barriers (i.e., lack of time for follow-up, contact with employers and incompatible legislation). In contrast, more specialized VR counselors experience less barriers and the barriers that they do experience are perceived as easier to overcome. Within their smaller and more innovative teams, more training and autonomy to pro-actively handle barriers is offered. In addition, more specialized VR counselors have more prolonged contacts and opportunities to interact with the clients compared to gatekeepers. This enables them to experience a positive counseling process which may strengthen their self-efficacy (Bandura, 2001). Less visible outcomes, such as increased integration into society, self-confidence and autonomy become more obvious for them (attitudes). Gatekeepers often lose contact with the person and are rarely informed about the final outcomes. The same is true for mental health practitioners working in mental hospitals. They are regularly confronted with people who need to be hospitalized again and may thus become less positive about patients' futures. Thus, offering information about positive outcomes is crucial. It contributes to job motivation, involvement and realistic assessment of one's own competences (Bakker & Demerouti, 2007; Murphy & Cleveland, 1995). When counselors experience a lack of feedback about the final outcomes, they are more likely to rely on the overall -and often less positive- prevailing attitudes towards employment of people with SMI, in other words, they are prone to bias (Bandura, 2001; Holmes & Karst, 1990).

2. Strengths, limitations and future perspectives

Some strengths and limitations of the various empirical studies are discussed below.

2.1 Strengths

This doctoral research partly focused on vocational goals of hospitalized patients. Until now, vocational goals of hospitalized patients have not been the focus of many studies outside the US or UK and previous research focused on goals of non-hospitalized people. Therefore, we tried to increase knowledge concerning this group. We also included counselors' perspectives of each of their patients. Other studies mostly assessed counselors' general perspective of the entire group of people with SMI. The fact that counselors needed to think of the vocational options for a specific patient was new (for a noteworthy exception see Marwaha et al., 2009). An additional strength of this part of the doctoral research is that it was conducted in collaboration with mental health practitioners and patients. The questions and the structure of the questionnaire were adapted in order to maximize the participation of counselors who experience a high workload and are often less motivated to participate in research. The advantage of the expert panels of patients is that input could be used to reword questions and to estimate time to complete the questionnaire. The involvement of counselors and patients increases the possibility that the results of the study are taken up afterwards.

Another part of the research zoomed in on the VR counselor as (s)he strongly influences employment outcomes (Capella & Andrew, 2004; Catty et al., 2011; Gowdy et al., 2003). Most prior studies studied overall attitudes of counselors but we incorporated also norms, self-efficacy, perceived control and prior behavior. Hence, an overall framework of counselors' intentions to focus on competitive jobs could be created. This framework is based on context-specific measures, i.e., belief-based measures of local VR counselors. Although such measures may limit generalizability to other contexts, multiple benefits exist (Hartung, Taber, & Richard, 2005). A major advantage is that context-specific measures improve face validity, comprehensibility and prediction of outcomes. Using the TPB, this study brings a contribution to the TPB research methodology as well as more sophisticated structural equation modeling (SEM) techniques were used.

2.2 Limitations

Notwithstanding the strengths, the studies have some limitations as well. Because most limitations were already described in the manuscripts, we highlight the most important and add some overall limitations.

A first set of limitations concerns the study of hospitalized patients and counselors. The sample comprised people who were in a turbulent phase of their lives and people who were taking medications that are known for their side-effects. Therefore, the questionnaire was constructed as easy as possible and this was checked by expert groups of patients. But even then, it may have been too difficult or lengthy for some to respond to the questionnaire. This may have resulted in a bias and we assume that people who did not respond were less interested in competitive employment than those who did respond. Yet, this remains a hypothesis that can only be confirmed with more (qualitative) research.

Concerning the questionnaire, many differences in operationalizing the question “Is someone motivated to work?” exist between studies but no single valid and reliable instrument exists. After a literature study and offering different formats to mental health practitioners, VR counselors and patients, we opted to use an improved version of the operationalization of Secker, Grove and Seebohm (2001). Further studies need to establish a reliable and valid measurement of people’s intentions to work.

Another caveat relates to the data gathering. Although seven psychiatric hospitals were involved, not all wards participated due to a lack of interest or time constraints. Ideally, the study comprised a more representative sample of patients by including more and more diverse hospitals and wards.

Another limitation relates to international comparisons. As we did not assess severity of symptoms, number of hospitalizations or psychiatric diagnoses it is hard to make comparisons with other studies’ samples. We did not take up these measures as they would have obliged us to include other (lengthy) questionnaires and the participation of psychiatrists. Both actions would have resulted in fewer responses. An interesting follow-up study would consist of comparing the profile of hospitalized patients in different countries and how this may affect vocational interest and perceived barriers.

Some other limitations concern the study of the VR counselor. When using the IPS Fidelity scale, it is best to analyze written documents such as agencies’ business reports. Yet, business reports were often lacking or did not report the needed information. Moreover, the finding that IPS is not yet

implemented in Belgium needs to be interpreted with caution because we used only a small sample from all employment services.

Next, we used the TPB as an a priori framework in the study of VR counselor's intentions. Although this had some advantages, we are aware that we did not include other important variables. We resolved this by including high-promising variables (e.g., moral norms and prior behavior). One such important variable that was not included is actual behavior. Many TPB-studies do not include this variable due to problems of operationalization. Armitage and Conner (2001) state that when a measure of actual behavior ('How do you act?') is contemporaneously offered with a measure of intentions ('How do you intend to act?') researchers are not measuring actual behavior but past behavior (because behavior is always performed after intentions are (unconsciously) made). Longitudinal or prospective measures are therefore better suited to measure actual behavior (Armitage & Conner, 2001). Yet, prospective measures may be prone to social desirability. Therefore, we recommend setting up a longitudinal study in which clients are followed during their VR process and the effects of working alliances with counselors are investigated. Such a longitudinal study is now possible due to the improved contacts with the different stakeholders. Other possible models and variables that are promising for future research are described in the appendices, including (i) the ASE-model (Vries & Mudde, 1998), (ii) the Integrated Change Model (I-change) (de Vries et al., 2003; Vries et al., 2005), (iii) the Health belief model of Hochbaum (1958) (Rimer, 2008) and the (iv) the Integrated Behavioral Model (IBM) (Montano & Kasprzyk, 2008a).

A next caveat is that the study did not use a (quasi-)experimental or longitudinal design. Therefore, our results represent associations and not causal relationships. To study effects and causes, an intervention should have been implemented. This study was the first to describe a framework that can now be used to design and evaluate future training interventions. But before this, our model must be subjected to rigorous replication, just as any new model. Replications need to measure constructs with more than two to four items per construct to increase reliability. Future studies also need to increase sample size. The relatively 'low' number of responses (55%) might reflect a negative attitude towards contributing to research or barriers such as a high caseload. More respondents would have resulted in more reliable results and would make it possible to include belief-based measures in structural equation analyses instead of the overall measures of the TPB-components (latent constructs). Nevertheless, we have to stress that the overall population in our region is not large and that we reached a good response rate that is comparable to other international studies (Cook, Dickinson, & Eccles, 2009; Dykema, Jones, Piché, & Stevenson, 2013; Ramsay, Thomas, Croal, Grimshaw, & Eccles, 2010).

Another limitation concerns the generalizability of our results. As these findings originate from the specific Flemish VR system, we cannot guarantee their full applicability in the Walloon part of

Belgium or in other countries. The overall VR process seems to resemble the systems in other economically developed countries. VR is supervised by a federal organization that is responsible for paying benefits and offering overall gatekeeping services. Smaller and regionally dispersed local VR services take up on-the-job support. In most countries, people with SMI go through different services before individualized evidence based services are offered (Fioritti et al., 2014; Premuda-Conti & Lewis, 2011). Yet, generalizability may be limited due to for example differing attitudes, social norms and barriers in different regions. Even more, we noticed in our study on beliefs of VR counselors that there exist some differences between different types of VR counselors. As a result, the TPB-model may be slightly different for each specific type of VR counselor. Yet, we tested this and only few and non-significant differences emerged (e.g., slightly more effect of self-efficacy for VR specialists). As a result, the overall model represents the 'average Flemish VR counselor'. Although it offers important insights for other researchers (e.g., the importance of moral and social norms), it has to be re-tested for other countries and for specific organizations/professional groups.

Next, the social desirability factor needs to be taken into account. Even when it is clearly stated that surveys are anonymous, counselors may have tailored their responses in order to make a good impression.

Lastly, one important 'limitation' is that we did not make a difference between diagnostic groups. We partly accounted for differences between people suffering from different mental health problems in the study with hospitalized patients. Results showed that motivation to work was associated with the type of mental health problem. Even mental health practitioners made a difference. We can therefore assume that the same holds for VR counselors' intentions to focus on competitive jobs. In our initial questionnaire, one item concerned VR counselors' intentions to focus on competitive employment when faced by different aspects of people (i.e., different diagnoses, different ages, different level of motivation of the person, different educational degrees and different levels of vocational experience). Results show that VR counselors will focus less on competitive jobs in the case the person suffers from schizophrenia, is older than 50 years, is not motivated to work, is less educated and has no vocational experience. These results were however not (yet) communicated in the form of a scientific article. Thus, the overall TPB-model can be different when the counselor is faced with a different type of mental health problem. Yet, VR counselors are rarely confronted with only one type of disorder and it was thus more important to create a solid framework incorporating all people with SMI. This offers levers to action which can be later refined for specific target groups. Moreover, even within one diagnostic group, level of functioning can be very different among people. That is why the new definitions of SMI focus more on the level of functioning than on type of disability. People with major depression can experience more difficulties with functioning than for example people with schizophrenia that is well-treated. In addition, the evidence-based practice IPS

states that 'no exclusion criteria for IPS exist'. Whether someone suffers from schizophrenia or depression, is older or younger than 30 or has a Master's degree or not, is relatively unimportant as the VR counselor needs to focus on competitive jobs if the person desires this. We do acknowledge that knowing that for example for people with schizophrenia, VR counselor never intend to focus on competitive employment, may offer levers to better training and awareness campaigns.

2.3 Characteristics of the research in this PhD

Academic studies in which all outside factors are kept under the researchers' control are highly valued. Nevertheless, much of the evidence from these controlled laboratory studies does not fit the complex realities of public health practice (Green, 2006). As a consequence, academic research outcomes often fail to find its way into policy and practice (Glasgow, Lichtenstein, & Marcus, 2003). The gap between research and practice can be addressed by knowledge infrastructures that link policy makers, researchers and practitioners. This way, researchers can access interesting problems that are often too complex to be recreated at laboratory level. In addition, researchers can rapidly pick up signals regarding topics that are becoming important in daily practice. As such, collaboration between policy makers, practitioners and researchers opens the possibility of defining new areas of research (Elg, 2014). In the Netherlands, collaboration between the abovementioned partners led to practical, scientific and knowledge increasing "Academic workshops". In Belgium, LUCAS of the University of Leuven is such a multidisciplinary knowledge infrastructure that conducts action oriented research on the crossroad of science, policy and practice.

Although the advantages of practice oriented research are multitude, it is also fraught with some challenges. Firstly, research is often done on a per project basis. Such projects limit the time and means of research teams by which highly-controlled studies are less evident. Secondly, practice oriented research is confronted with complex contexts and less-controllable factors such as policy changes, cultural influences and the fact that it often depends on existing partnerships (Young, 2007). As a result, the researchers must take advantage of unexpected opportunities, must be highly flexible and must respond to needs of project partners. The cross-sectional studies of this doctoral research were possible due to the fostering of good contacts with different VR organizations (VDAB, GTB and GOB, see chapter 1) and psychiatric hospitals. Ideally, cross-sectional studies are complemented with randomized controlled trials. However, these are hard to realize in real-life contexts as current national insurance and other laws impede the implementation of models' principles. Until there is enough support to move forwards to intervention studies, less scientific rigorous studies of (parts of) the IPS-model need to rouse policy makers' interest. During this PhD-

project the researchers were able to stimulate the National Service for Medical and Disablement Insurance (RIZIV) and the Public Employment Service (VDAB) to conduct more studies. Moreover, the collaboration between researchers, practitioners and policy makers resulted in output that was a stepping stone for the development of different Flemish policy recommendations (e.g., w² (werk-welzijn)) and the implementation of vocational coaches in community-based revalidation centers.

Project based research also enlarges the role of the researcher. They become increasingly co-responsible for the dissemination and the development of policy guidelines or handbooks and the organization of symposia for professionals. These types of output are increasingly recognized as valuable output (and impact) in the academic world. In the context of this doctoral research, a small handbook for VR supervisors (Werk Werkt![5]) was created and diverse symposia concerning Supported Employment and multidisciplinary collaboration were organized.

In sum, although practice oriented research may be hampered by external factors, it has the merit that output is relevant for everyday practice and for policy makers. This makes dissemination of findings easier and its large-scale adoption becomes more realistic.

3. Suggestions for future research

The studies' findings and limitations offer suggestions for future research. We will highlight potential research directions by stating some research questions and methods.

3.1 Studies of hospitalized patients and their mental health practitioners

Our study of the vocational goals of hospitalized patients and mental health practitioners showed a relatively low interest in competitive employment of both parties. We partly attributed this to the samples' characteristics, a lack of adapted legislations, low expectations of practitioners and patients themselves (interpersonal expectancy effect) and the tradition to focus less on competitive employment (Rinaldi et al., 2008). Yet, some additional research is needed.

A longitudinal design can investigate the existence of an **"interpersonal expectancy effect of mental health practitioners on patients"**. Such a study needs to register vocational goals, self-efficacy and perceived barriers to employment of both parties on at least three occasions: before, during and after hospitalization of the patient. When the competitive employment interest of the patient decreases after controlling for other variables such as diagnoses, this may indicate an interpersonal

[5] http://www.gtb-vlaanderen.be/docs/default-source/default-document-library/gtb_werkschrift5_web.pdf?sfvrsn=2

expectancy effect. Although interesting, the design will be difficult to implement because a pre-test (before hospitalization) is practically impossible. A solution may be to include people at the beginning of their hospitalization, but the fact that one is submerged in the world of psychiatry can already have had some effects. Another option is to compare the evolution of competitive employment interest of patients staying at psychiatric wards with a different policy concerning VR.

Another study may answer **"What are the reasons why some people with SMI do no longer want a competitive job?"**. A fruitful method is the combination of a qualitative explorative study and a quantitative cross-sectional study of hospitalized patients, unemployment beneficiaries and/or disability beneficiaries. By means of semi-structured interviews, people with the most severe forms of mental illness can participle as well. The study can be guided by a theoretical framework such as the I-change model in order to create a solid framework of intentions. The I-change model may be valuable because it incorporates all basic variables of the Theory of Planned Behavior and important additional variables. Some of these additional variables belong to the Transtheoretical Model of Behavior Change of Prochaska and DiClemente. This model assesses an individual's readiness to act on a new behavior and provides strategies to support the person through the stages of change. After the quantitative phase, additional interviews with subsamples of people with for example schizophrenia or a criminal background may offer even more concrete recommendations for policy makers and professionals.

With respect to answering **"How can employment interest be increased?"** we advise a multi-centered study in which some psychiatric wards or rehabilitation centers act as a control group (treatment as usual) and others as an intervention group. Interventions can consist of offering information of evidence-based practices, training programs of mental health practitioners to assess vocational goals, cross-training and offering information to counselors and patients by an external VR counselor and a person with lived experience (Marks, Sabella, Burke, & Zaccaro, 2002).

3.2 Vocational rehabilitation counselors

Our study showed that a focus on competitive employment was partly determined by attitudes, prior behavior and norms. To answer **"Which other determinants are related to a competitive employment focus?"** other theoretical frameworks, such as the Integrated Change Model, can be used (de Vries et al., 2003; Voncken-Brewster et al., 2014; Vries et al., 2005). This model is a very complete model of behavior change and integrates variables from various other social cognitive models (see appendix). Some variables can be measured using the BAKES-scale (Behavior, Attitude and Knowledge of Employment Specialists) (Corbière, Brouwers, Lanctôt, & Van Weeghel, 2014). This scale consists of 90 crucial VR counselors' competencies spread over 12 subscales. This scale was not

used in our study as we needed a more comprehensive questionnaire in order to maximize the response rate. Results of additional studies on determinants of competitive employment focus can be used to create a multi-center intervention study to investigate training programs for VR counselors. Training programs can consist of for example offering people success stories, evidence from evidence-based practices, supervision and group discussions about the value of employment. Ideally, they are offered to mental health practitioners at the same time.

Additional important determinants that need to be further investigated are 'prior successes' and 'feelings towards prior counseling'. These variables were included in the questionnaire of this study, and were highly correlated to prior behavior. Yet, incorporating them decreased the models goodness-of-fit statistics and the model's validity and reliability. It seems important to further study the role of 'prior successes' and 'feelings towards prior behavior' in the Theory of Planned Behavior.

3.3 The VR process of people with SMI

Much international evidence exists concerning the barriers and success factors of VR of people with SMI. Nevertheless, Belgium is in some aspects different from other countries and more evidence is needed to answer: **"Which elements determine a successful VR process in Belgium?"**. We advise a 5-year longitudinal study in which people with SMI and/or more common mental disorders will be followed and different variables will be assessed (e.g., received VR and mental health care support, diagnosis, type of benefits received, support from social network and number of referrals between organizations). We also recommend including measures of attitudes towards employment and intentions of the involved actors. By this, the effects of the number of referrals and the lack of agreement between involved actors can be studied. Ideally, the study will be organized in different countries.

3.4 Family members and friends

Family members and friends can be both a stimulating factor and a barrier in the VR process of people with SMI (Alverson, Alverson, Drake, & Becker, 1998; McFarlane et al., 2000; Murphy, Mullena, & Spagnolo, 2005). Yet, they are often overlooked and the effect of their natural support is often not included as a variable in studies. It would be interesting to study the effects of an intervention that focuses on family members and friends. They can be offered information concerning the value of employment and training to improve supporting skills.

3.5 The implementation of IPS

We recommend setting up a multisite study of IPS such as was done in for example the Netherlands (Fioritti et al., 2014; van Erp et al., 2007). The latest Cochrane review of IPS studies commends more standardized vocational and non-vocational measures because many studies are now difficult to compare (Kinoshita et al., 2013). The most important variable will be job acquisition (competitive employment rate) indicating the percentage of participants employed at any time. We offer some other recommended vocational measures, non-vocational measures and economic indicators in the appendices (Kinoshita et al., 2013; Michon et al., 2014). In addition, to asses IPS Fidelity, the IPS Fidelity scale needs to be assessed regularly.

3.6 Other recommended studies

The abovementioned recommendations are not sufficient to attain stable high competitive employment rates. For this, other stakeholders need to be involved, including employers and policy makers. Concerning employers, many studies already reported their attitudes, experienced barriers or past experiences (Biggs, Hovey, Tyson, & MacDonald, 2010; Chan et al., 2010; Copeland, Chan, Bezyak, & Fraser, 2010; Kaye et al., 2011; Solovieva, Dowler, & Walls, 2011). Yet, no framework exists of the interactions between these variables and thus the question remains **"Which factors determine employers' decisions to hire people suffering from mental health disorders?"**. As our study showed that attitudes and behaviors are not the most single determinants of counselors' intentions, this may also be the case for employers. Interventions addressing attitudes and barriers in order to stimulate employers to hire people with SMI, may thus be insufficient. A study using an extended TPB-framework can be useful to better comprehend and link employers' attitudes, norms, perceived barriers, the organizations' characteristics, etc.

4. Implications and general policy recommendations

Some implications for policy and practice can be deduced; the implementation of evidence-based programs, increasing collaboration between services, promoting the benefits of employment for all and training of counselors and mental health practitioners.

4.1 To implement evidence-based practices

During this research it became apparent that Supported Employment is not yet widespread in Flanders. Recently, the National Service for Medical and Disablement Insurance (RIZIV) stimulated Belgian provinces to create community-based 'rehabilitation centers' outside the psychiatric hospital. These centers will offer ambulant psychosocial support (acquiring skills, improving living conditions…) by a multidisciplinary team (psychiatrist, psychologist, social worker) to a maximum of 12 full-time clients who visit the center. The RIZIV obliges every center to hire a vocational coach, although the specific job tasks of the vocational coach were not stipulated. After this research, we strongly recommended our partners and the RIZIV to not only focus on sheltered or transitional employment but also on Supported Employment programs and thus on competitive jobs. Otherwise they risk implementing Clubhouse-models that might be beneficial for some, but that do not lead to higher overall competitive employment outcomes. In contrast, we also recommend the centers to offer multidisciplinary and outreaching support close to patients natural environment as is done in (Flexible) Assertive Community Treatment ((F)ACT) instead of at the clinic or at centers (Drukker, Visser, Sytema, & van Os, 2013). FACT is a rehabilitation-oriented clinical case management model that is able to serve a broad range of people with SMI. FACT teams offer case management with an individual approach and/or a team approach depending on the person's needs (Delespaul et al., 2014; van Veldhuizen, 2007).

With respect to the 'vocational coach' stipulated by the RIZIV, we advise the rehabilitation centers to hire a vocational coach of the existing Employment Services (GTB, GOB). This coach takes up the role of a spokesman of competitive jobs and incorporates both case management and on-the-job coaching. As a result of the increased informal contact due to co-location, mental health practitioners will receive feedback about the outcomes of the VR process. This is, as our TPB-study showed, important to influence the intention to focus on competitive jobs.

Because not all people with mental illness will receive services from these community based centers, the current VR organizations need to make work of a job profile in which the counselor can merge existing case managers' functions with on-the-job coaching. Currently, the client is often referred to different organizations and counselors. Policy makers often state that the advantage of such

geographical dispersed counselors is that it helps the client to learn how to deal with different people and how to act in different contexts. Yet, it remains questionable whether engaging different counselors will increase coping skills of clients and will lead to higher employment rates. Especially when, as the study shows, dissimilar beliefs and intentions between different counselors exist.

What about the reported barriers such as inconsistent regulations, a lack of motivation from the client or instability of the mental health state? Earlier research showed that some of these reported barriers can be overcome when implementing high fidelity Supported Employment programs. Such programs need to be coupled with outreaching and multidisciplinary programs such as the abovementioned (F)ACT-model. When implementing such programs, it is crucial to address counselors' and supervisors' attitudes (Bond et al., 2001a; Gowdy et al., 2004); supervisors need to openly defend the evidence-based principles and the competitive job search for people with SMI (Corrigan et al., 2001; O'Brien et al., 2003; Rapp et al., 2008).

When implementing IPS, the program costs will, in the first years, be probably higher than that of traditional vocational centers. Yet, because IPS produces better outcomes than alternative vocational services and at a lower cost overall to the health and social care systems, IPS is probably cost-saving and certainly more cost-effective (Knapp et al., 2013). Yet, the proof of cost-effectiveness results from studies outside Belgium. To check whether IPS is also cost-efficient in Belgium, more studies need to be set up. Moreover, when implementing IPS, we advise that policy makers are involved so that hindering legislation can be detected and adapted. This is better than the current approach in which IPS principles are adapted so that programs fit the current legislation.

4.2 To increase collaboration between services

As already mentioned (Figure 4, page 17), Belgium has different organizations that are responsible for different phases of the (vocational) rehabilitation process. An increased collaboration or even an amalgamation of these different services needs to be stimulated by means of joint education, training and supervision (Van Weeghel et al., 2013). This will strengthen positive attitudes and will create possibilities to share solutions for common problems.

Not only is collaboration within the field of VR organizations essential, alliances with mental health organizations are even important (Van Weeghel et al., 2013). In Belgium, employment and mental health care are historically the responsibility of two different governmental departments and little cooperation between the two exists on a macro level (OECD, 2013b). On the level of the counselors, there is also a lack of trust and collaboration. Mental health practitioners regularly state that VR counselors are too coercive and that employment is too stressful for their patient population. On the

other side, VR counselors often experience too little support from mental health care professionals which is needed to better understand people's symptoms, pitfalls and skills. To increase collaboration between mental health and VR services it is essential that professionals learn more about the other professionals' methods and skills by cross-training (Marks et al., 2002). Knowledge and trust can be increased by for example mutual training and sharing caseloads. Also, co-locating VR counselors at mental health organizations will increase informal contacts and makes the employment outcomes and benefits of work (e.g., integration, income) more visible (Campbell et al., 2007; Fox, 2013; Rucci et al., 2012). Co-location makes it also possible to offer immediate process feedback during face-to-face contacts between counselors which will raise the motivation and involvement of all parties, even those who have no longer contact with the client/patient (Bakker & Demerouti, 2007). Another possibility is to create knowledge sharing platforms that facilitate the sharing of ideas, methods and results of services and will in turn lead to more integrated services.

4.3 To improve VR by education and training

As abovementioned, it is paramount that the delay between hospitalization and first VR steps is reduced. Our study showed that many hospitalized patients still hold short and long term vocational goals including competitive jobs. In Belgium (and other countries), there is less tradition to focus quickly on the vocational goals of the hospitalized patient. As a result, people who still have a job but become hospitalized may risk losing contact with the work floor. In turn, there is a danger for misunderstandings, a lack of high-needed work adjustments when the person returns to the work floor or even job loss.

To prevent this, (mental) health practitioners need to be made aware of the importance of employment and need to be trained to sufficiently assess people's goals concerning employment, housing, relationships… It is also important they are trained in motivational interviewing and evidence-based models such as IPS. This is equally vital for primary care professionals although they are often less trained in specific skills and are less aware of evidence-based practices (Szymanski, 1991). Training programs need to equip counselors with both generalist and specialist competences (Ayanian et al., 1994; Fleming, Del Valle, Kim, & Leahy, 2013; Marshall et al., 2008). This will result in more positive attitudes towards evidence based practices and ultimately lead to higher referral rates to VR programs (Bond et al., 2001a; Gowdy et al., 2004; Torrey, Bond, McHugo, & Swain, 2012).

In addition, we want to address the education and training of VR counselors in specific (Van Weeghel et al., 2013). In Flanders, no formal training of VR counselors exists and every Employment Service (VDAB, GTB, GOB) has its own internal training. Their trainings are often shaped by VR counselors

who have valuable clinical experience but who may lack knowledge of state-of-the-art research. Moreover, as they are dependent of their employer, they will be less likely to transfer information that is contradictory with the used methods of the organization. For example, when an organization is restricted by law in how much time may be spend for on-the-job coaching, it will be more likely that this principle of on-the-job coaching gets less attention. In order to offer future VR counselors a high-quality education, we support the creation of more formal and academically supported education programs in addition to trainings by experienced VR counselors. There should be a core set of topics that is offered as a minimum to all three organizations (VDAB, GTB and GOB), including for example motivational interviewing and International Classification of Functioning (ICF). Every VR counselor that comes into contact with employers and clients, needs to be able to form relationships with employers and supervisors, and needs to be able to offer support while adopting a client-centered approach (Corbière, Brouwers, Lanctôt, & van Weeghel, 2013). These skills affect vocational rehabilitation outcomes the most. In addition, VR counselors of the GTB and GOB need to be fully aware of the Individual Placement and Support model. Although not all legislation is adapted so that teams can fully adopt IPS practices, many principles and high-needed skills can be taught using the manuals of the Dartmouth IPS Supported Employment Center in the USA.

4.4 Policy makers, employers and the general population

At the start of this thesis, we decided to focus on people suffering from mental illness and counselors. We now want to address some overall recommendations that are addressed to other key figures including policy makers, governmental departments, employers and the general population.

First, better identification and support are hindered by non-disclosure due to a lack of awareness that a person experiences mental health problems (often for personality disorders) or due to stigma and discrimination (Dalgin & Gilbride, 2003; Dezetter et al., 2013; OECD, 2012; Van Weeghel et al., 2013). Policy needs to influence society and workplaces so that the advantages of disclosing mental disorders outweigh the disadvantages (OECD, 2012). Acceptance of people with mental health problems will make it easier for those unemployed to seek support. Until now, they often do not want to disclose their problems and their apparent difficult behavior is often attributed to a lack of motivation (OECD, 2013b). Less stigmatizing views may not only result in more unemployed people asking help but also in an increase of employed people asking on-the-job support when there exists a risk of losing their jobs due to mental health problems (OECD, 2013b). We strongly recommend that more attention is given to people still employed as it may prevent dismissals or prolonged unemployment when fired (OECD, 2013b).

Being fired due to mental health problems can also be prevented by increasing the (financial) support and follow-up of employers (Brohan et al., 2014; Kaye et al., 2011; Solovieva et al., 2011). Support to employers is underdeveloped or often unknown in Belgium (OECD, 2013b). As a result of increased (financial) support, employers may be more motivated to develop adequate rehabilitation plans and sickness management policies that are adapted to people with mental health problems. The OECD even recommends rewarding employers who reintegrate an employee after a long-term sick leave (OECD, 2012; OECD, 2013b).

Another important recommendation concerns the collaboration between different involved doctors (mutuality doctors, company's occupational doctor and general practitioners) and other professionals (psychologists, social workers…). This can be done through shared electronic information systems and the use of multidisciplinary guidelines (e.g., 'Werk en psyche' of the Netherlands Society of Occupational Medicine). In addition, regular face to face meetings between doctors and other professionals and workplace visits may increase mutual trust and may result in more coordinated services. These actions may also increase knowledge of general practitioners (GP's) concerning occupational health, something which is often not yet properly addressed during medical training (Gehanno, 2014). GP's are an important actor as they often have more background knowledge concerning the person and have stronger working alliances.

Moreover, each sickness beneficiary who is at risk of long-term incapacity needs to be seen by a doctor at the end of one month of absence. Moreover, a rehabilitation plan with concrete steps for returning to work and for evaluating progress should be created timely and needs to be updated yearly (OECD, 2013b). This can be done in close collaboration with VR counselors. If the doctors and the employee consider reintegration in the current job as no longer feasible, the public employment service (VDAB) and its gatekeepers need to be involved immediately to prevent protracted unemployment.

We also see an important role for the general practitioners due to the increase of community-based care (Van Weeghel et al., 2013). Their sick-listing behavior needs to be studied as the currently offered "period of rest" may not always be useful in the case of mental health problems. The current "sickness-absence laws" are based on a traditional medical model and are not adapted to mental health problems. They need to be more flexible, mental health problems are often of a cyclic nature and cannot be compared with diseases such as for example cancer. Policies and work adjustments need to take into account that the symptoms with which people with mental health problems are confronted will often reoccur. Instead of prescribing a couple of weeks of total absence from the work floor, it may be better to prescribe reduced labor time. In addition, other regulations and activation measures need to be adapted to the specific nature of mental health problems. Unemployed people with mental illness also have to get the chance to discover what they still want

and can do without the risk of losing their benefits entitlement when participation in a VR program does not result in immediate employment (OECD, 2013b).

5. Conclusion

The different studies have shown that hospitalized people suffering from SMI and their mental health practitioners have different perspectives concerning vocational goals, barriers to employment and needed supports. This can be detrimental for the further working alliance and VR process. Therefore, it is important that VR counselors are involved as quickly as possible. They can stimulate the patient and the mental health practitioner to truly consider competitive employment as a valuable option. For this, VR counselors themselves need to be motivated to look for competitive jobs. They should be supported by their supervisors and colleagues and they need to be trained in evidence-based practices. Moreover, governments should implement policies and legislation that foster the implementation of the evidence-based IPS-model. To increase the demand for competitive jobs and on-the-job coaching, it is important that mental health problems are no longer regarded as disabling people to work. An important work will thus be to reduce negative attitudes towards mental health problems.

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Appendices

1. Other frameworks

1.1 The ASE-model

The ASE-model (Vries & Mudde, 1998) resembles the TPB-model as it states that behavior is a function of a person's intentions. Intentions are assumed to be most directly determined by three types of proximal cognitive factors: attitudes, social influences, and self-efficacy expectations.
The TPB and ASE differ on several points:

1. The ASE measures two indicators of attitudes: an affective component and a cognitive component. Nowadays, more and more TPB-studies also include both components.
2. The ASE-model distinguishes three types of social influences: social norms, perceived behaviors of others, and direct pressure or support to perform a particular behavior.
3. Four types of distal factors are influencing the ASE-variables, i.e., behavioral factors, psychological factors, biological factors, and social and cultural factors.
4. Compared to other models, the ASE-model incorporates three specific information factors that influence the effectiveness of an intervention that aims to motivate an individual to change: message factors (e.g., how much the message and the opinions of the individual differ); channel variables (e.g., the level of overlap between the technical characteristics of the message and the individual's preferences); and source variables (e.g., reliability and credibility of the source as perceived by the individual) (Vries & Mudde, 1998).

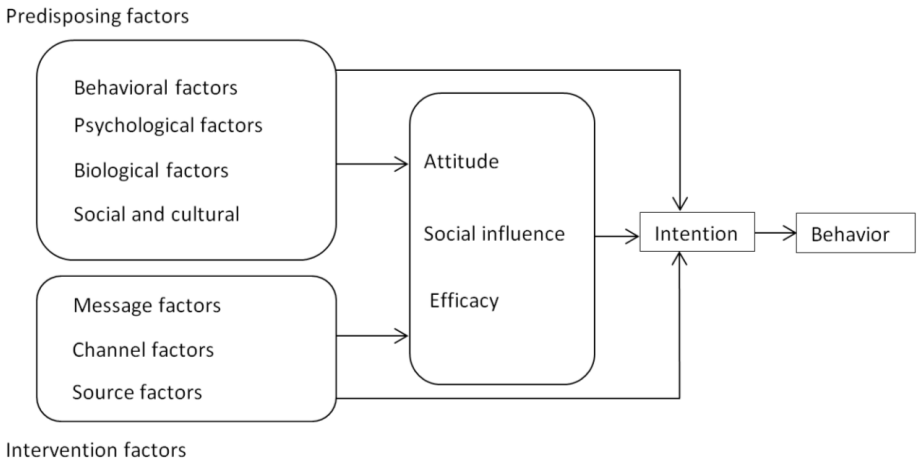

Figure 13. The ASE-model

1.2 The Health belief model

The Health belief model of Hochbaum (1958) is most often used to explain the change and maintenance of health-related behaviors (Rimer, 2008). It resembles the TPB as it takes up variables such as perceived barriers and self-efficacy. In addition, the model includes susceptibility to and seriousness of a disease, benefits to perform a behavior, and cues to action. According to the model, individuals are likely to take action if they (Rimer, 2008):

- regard themselves as susceptible to a condition with potentially serious consequences
- believe that a (series of) action(s) would help to reduce the susceptibility to or severity of the condition
- believe the anticipated benefits of taking action outweigh the barriers to (or costs of) action(s)

In the context of this PhD, the individuals are not confronted with health conditions with potentially serious consequences and thus many concepts are less useful. The model would be more instrumental when studying the motivation of people with SMI to work.

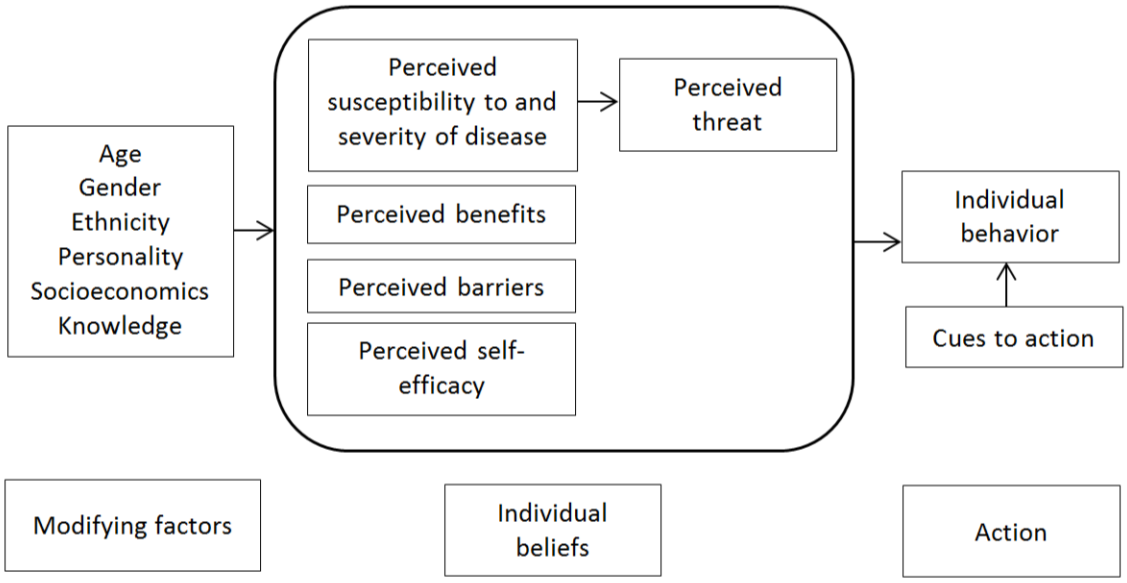

Figure 14. Health Belief Model Components and Linkages

1.3 The Integrated Change Model

The Integrated Change Model (I-change) is a comprehensive model resulting from the ASE-model and incorporating variables of other models such as the TRA, TPB, or Social Cognitive Theory (de Vries et al., 2003; Vries et al., 2005).

Predisposing factors (biological, social or other nature) and information factors (ASE-variables) influence how aware the individual is of his behavior. All these factors contribute to the attitudes, social norms and efficacy of a person (TPB-variables). Depending on these factors a person can be not, not yet or ready for change (Transtheoretical model of Prochaska and Diclemente) (Prochaska, Redding, & Evers, 2013). When the person is supported and there are no insurmountable barriers, the person can decide to act.

Although this model incorporates many variables from other models, it is also very complex. Because we aim to construct a model that is applicable in the context of individual counseling and supervising and the resulting questionnaire may not be too extensive, it would be more efficient to start with a less extensive framework.

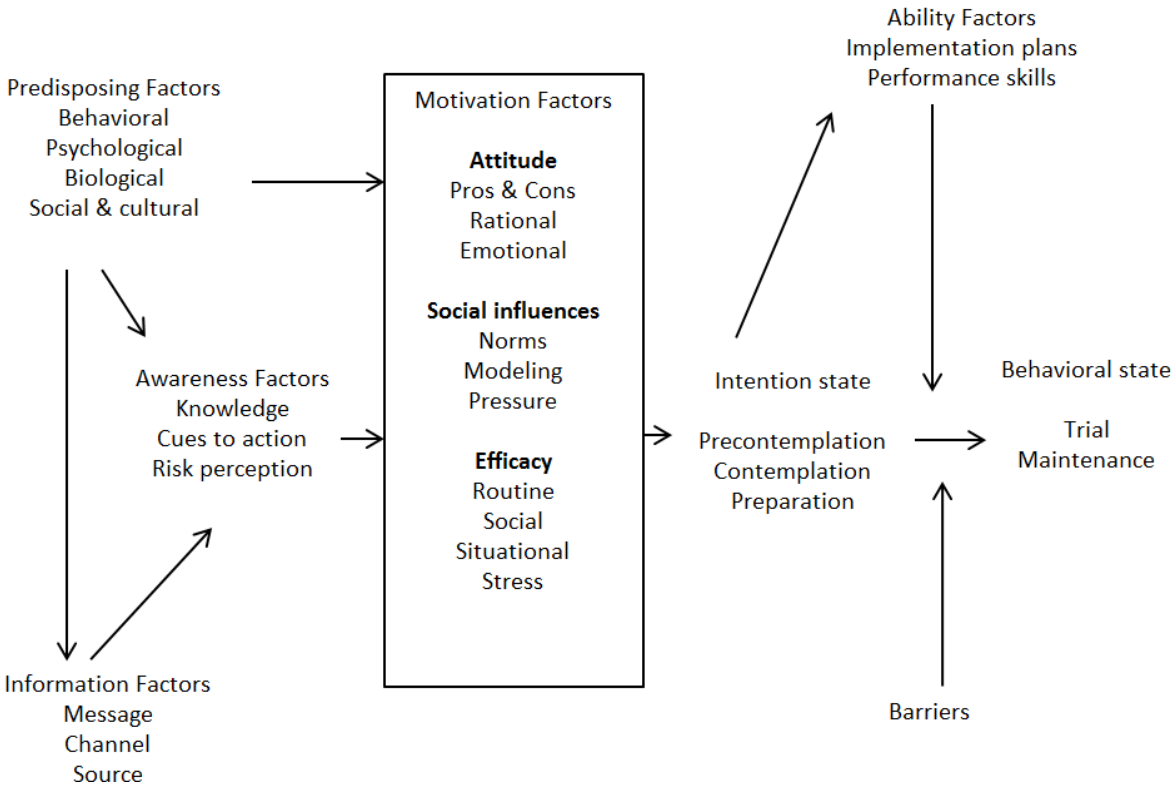

Figure 15. The I-change model

1.4 The Integrated Behavioral Model

The Integrated Behavioral Model (IBM) includes most variables of the TPB-model and some other additional constructs (Montano & Kasprzyk, 2008a). These additional constructs consist of knowledge and skills to perform the behavior, salience of the behavior, environmental constraints and habit. These variables are presumed to affect behavior and not intentions. As counselors' behavior is not easy to measure (due to the complex VR situation in Flanders with its many referrals, inconsistent regulations, long pre-vocational trainings…) incorporating these variables is 'redundant' and it is better to focus on a high quality measure of the other variables. As a result, the additional variables that affect behaviors are currently not taken up in the study. As explained in the section of the limitations, future research needs to study counselors' behaviors and these additional constraints.

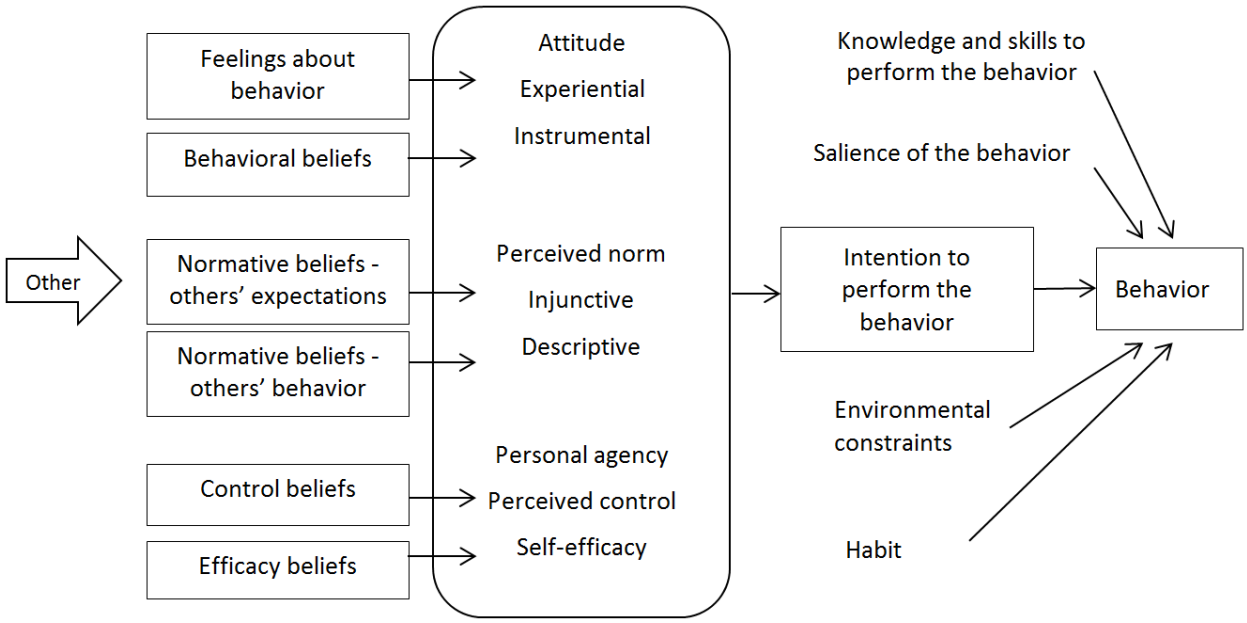

Figure 16. The Integrated Behavioral Model

2. Outcomes

2.1 Vocational outcomes

Important vocational outcomes are:

- job acquisition, i.e., competitive employment rate.

  The percentages of participants employed at any time. Although a crude indicator, it is useful as a general-purpose measure (Bond et al., 2012).

  Benchmarks can be: a minimal rate of 33%, a good performance rate of 45%, and a high-performance rate of 57% among active clients who receive IPS services (Becker, Drake, & Bond, 2011).
- total weeks worked
- tenure in the longest-held job (weeks worked on the longest-held competitive job),
- total hours worked,
- average hours per week worked,
- total wages (total earnings from competitive employment),
- days to first job, i.e., the number of days from entry into IPS/the alternative program to first competitive job. This is a negative indicator of successful employment because the longer the duration, the poorer the outcome.
- ever working ≥20 hours per week, i.e., working at least 20 hours a week at some time during follow-up (dichotomous measure)

2.2 Non-vocational measures

Non-vocational measures are less agreed on but we suggest to measure (Kinoshita et al., 2013; Michon et al., 2014):

- Mental health

  The Mental Health Inventory-5 is a short form of the 38 item Mental Health Inventory and assesses general mood, including depression, anxiety, and positive well-being in the last month (Gresenz, Sturm, & Tang, 2001). In addition, offering good care implicates engaging the patient as an active participant in dealing with his disorder. Ideally, the health care provider supports and guides the patient's self-care efforts ("supported self-management") and a measure of self-management can be valuable (Bilsker, Goldner, & Jones, 2007).

  - Service Use, measured by mean days in hospital and the number of participants admitted to hospital or re-hospitalized

- Quality of life

  The MANSA is an instrument for assessing quality of life focusing on satisfaction with life as a whole and with specific life domains (Priebe, Huxley, Knight, & Evans, 1999).

- General/social functioning

  The Global Assessment of Functioning (GAF) is a quick and simple measure (Jones, Thornicroft, Coffey, & Dunn, 1995). It provides a valid summary of symptoms and social functioning and is a commonly used assessment instrument for psychiatric patients. Derived from the GAF, the Social and Occupational Functional Assessment Scale (SOFAS) assesses an individual's level of social and occupational functioning independent of the overall severity of psychiatric symptoms (Burns & Patrick, 2007).

  The Personal and Social Performance Scale (PSP) is a more specific operationalization of the occupational, social, and personal functioning domains. Besides a global score, there are four subscales: work and study, personal and social relationships, self-care, and disturbing and aggressive behaviors (Juckel et al., 2008)

- Self-esteem and stigma

  The Rosenberg Self Esteem scale (Rosenberg, 1969) is the most widely used measure of self-esteem and global self-worth. It can be replaced by an even valid and single item measure called the single-Item Self-Esteem Scale (SISE) ("I have high self-esteem.") (Robins, Hendin, & Trzesniewski, 2001)

  Self-stigma is best measured using the Internalized Stigma of Mental Illness Scale (ISMI). It consist of 5 subscales: alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance (Boyd Ritsher, Otilingam, & Grajales, 2003; Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012)

- Recovery

  Overall recovery: The Recovery Assessment Scale (RAS) is a measure to assess the level of recovery. It comprises 5 factors: (i) personal confidence and hope; (ii) willingness to ask for help; (iii) goal and success orientation; (iv) reliance on others; and (v) symptom coping (McNaught, Caputi, Oades, & Deane, 2007).

  Psychosis related illness: The revised Questionnaire about the Process of Recovery (QPR) (Law, Neil, Dunn, & Morrison, 2014) is a valid measure of recovery from psychosis. It is a 15-item tool to measure the recovery process and to collaboratively set goals and monitor change (Law et al., 2014). Items are consistent with key themes identified in the

recovery literature, such as hope, meaning, empowerment, connectedness, identity and external support

Another promising and general tool designed to record and organize a wide range of information about health and health-related states is the ICF (International Classification of Functioning, Disability and Health). The ICF can also be used in needs assessment and rehabilitation and outcome evaluation (Escorpizo et al., 2010; Stucki et al., 2002).

2.3 Cost-effectiveness

A detailed economic evaluation to assess the cost-effectiveness of IPS compared with traditional VR services is necessary (Michon et al., 2014), yet not easy to make. It depends on what point of view is taken: that of the tax payer, of the society, of the health and social care system or of the individual. Some indicators are given (Hoffmann, Jäckel, Glauser, Mueser, & Kupper, 2014; Knapp et al., 2013; Mavranezouli et al., 2013):

- What are the costs associated with provision/running of IPS?
- Is it cost-beneficial? Do the outcomes achieved by IPS when expressed in monetary terms exceed the costs compared to other vocational rehabilitation services? This needs to be supplemented with the social return on investment which indicates the value of the social benefits in relation to the relative cost of achieving those benefits. Social return on investment thus includes the benefits that return to society due to increased purchasing power, partial independence from social benefit programs, tax revenue, etc. (Hoffmann et al., 2014).
- Costs for other services such as mental and physical health care and local authority costs

Professional career

Jeroen Knaeps was born on August 3th 1985 in Turnhout, Belgium. He graduated from high school at the Sint-Victorinstituut Turnhout, Belgium in 2003. He immediately started with his Bachelor and Master training at the University of Leuven and graduated in 2008 as a Master in Psychology with a focus on clinical psychology for adults. His thesis consisted of developing a Dutch scale to assess the appropriateness of telephonic reactions by counselors to people who threaten to commit suicide. After his Masters, he graduated at the School of Education of the University of Leuven enabling him to work as a teacher.

Between 2009 and 2010, Jeroen worked as a health counselor at the cardiac rehabilitation center of the Imelda-hospital in Bonheiden. He offered counseling and psycho-education to individuals who were operated and chose to rehabilitate while receiving support by a multi-disciplinary team of doctors, psychologists, physiotherapists and dieticians. He also supported the members of the Grandioos-project, a cognitive behavioral group therapy for people suffering from overweight. He also worked half-time at the palliative network in Mechelen where he offered support and practical assistance to team members (nurses) and volunteers. In this setting, he noticed the value of offering support at home.

After this clinical period in Jeroen's career, he started a PhD-training at the University of Leuven. More specifically, he joined the team of Lucas, a care center for research and consultancy. His PhD concerned the vocational rehabilitation (VR) of people with severe mental illness. He studied the determinants of VR counselors' intentions to focus on competitive employment using an a priori theoretical framework. Besides, Jeroen increased the knowledge concerning the vocational goals, needs and experienced barriers of hospitalized patients. Because Jeroen recognizes the importance of motivated and well-trained mental health practitioners, he also studied the expectations of mental health practitioners working at psychiatric hospitals.

In addition to his PhD-research, he contributed to the Open KennisNetwerk project and the ESF-project 'Supported Employment and Supported Education'. Both research projects aimed to study the possibility to implement Supported Employment and to advise policy makers about the value of evidence-based practices. These projects resulted in some conferences and concise handbooks. During the last years of his PhD-training, Jeroen contributed to the Belgian mental health care reform (article 107). He offered assistance to field organizations in order to increase the participation of users, families and their representatives in treatment and policy. Jeroen also contributed to research on the mental health care reform in Belgium and the European ADOCARE project concerning adolescent mental health care.

List of publications

1 Knaeps, J., DeSmet, A., & Van Audenhove, C. (2012). The IPS fidelity scale as a guideline to implement supported employment. *Journal of Vocational Rehabilitation, 37*(1), 13-23. doi: 10.3233/JVR-2012-0596

2 Knaeps, J., Neyens, I., Donceel, P., Van Weeghel, J., & Van Audenhove, C. (2014). Beliefs of Vocational Rehabilitation Counselors about competitive employment for people with severe mental illness in Belgium. *Rehabilitation Counseling Bulletin*, 1-13. doi: 0034355214531075.

3 Knaeps, J., Neyens, I., Donceel, P., Van Weeghel, J., & Van Audenhove, C. (2014). Counsellors' Focus on Competitive Employment for people with severe mental illness: An Application of the Theory of Planned Behaviour. *British Journal of Guidance and Counselling*. Accepted for publication. DOI: 10.1080/03069885.2015.1007443

4 Knaeps, J., Neyens, I., Donceel, P., Van Weeghel, J., & Van Audenhove, C. (2014). Perspectives of hospitalized patients with mental disorders and their counselors on vocational goals, barriers and steps to overcome barriers. *Journal of mental health*. (in review)

List of national and international presentations **(not exclusive)**

1 Knaeps, J., DeSmet, A., & Van Audenhove, C. Supported Employment Fidelity in Flemish Vocational Programs. The IXth Enmesh International Conference of the European Network For Mental Health Service Evaluation. Ulm, Germany. 23 July 2011. Oral poster presentation

2 Knaeps, J., & Van Audenhove, C. User and family members' involvement in the mental health care reform in Belgium: a pilot-study. The Xth Enmesh International Conference of the European Network For Mental Health Service Evaluation. Verona, Italy. 3 October 2013. Poster

3 Knaeps, J. & Van Audenhove, C. Supported Employment modelgetrouwheid in Vlaamse arbeidsrehabilitatieprogramma's. Zesde Vlaams GGZ-congres: Geestelijke Gezondheid (Sixth Flemish mental health care congress): Macht en kracht. Antwerp, Belgium. 18 September 2012. Presentation

4 Knaeps, J. & Van Audenhove, C. Participatie van patiënten, familieleden en hun vertegenwoordigers: Checklists. (Participation of users, family and their representatives:

Checklists). Studiedag en seminarie: "De meerwaarde van participatie in de zorgvernieuwing: Presentaties en uitwisseling". Brussels, Belgium. 18 October 2013. Presentation

5 Knaeps, J., Neyens, I., Derison, T., Gailly, L., & Van Audenhove, C. Werk Werkt!. Disseminatie-event voor professionals. 19 November 2013. Presentation

6 Knaeps, J., Neyens, I., Derison, T., Gailly, L., & Van Audenhove, C. Werk Werkt!. Studiedag Wetenschappelijke vereniging voor verzekeringsgeneeskunde “Start to re-integrate”. Leuven, Belgium. 23 April 2014. Presentation

7 Knaeps, J., Neyens, I., Derison, T., Gailly, L., & Van Audenhove, C. Werk Werkt! Zevende Vlaams GGZ-congres: Geestelijke Gezondheid (Seventh Flemish mental health care congress). Antwerp, Belgium. 16 September 2014. Poster presentation

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